REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • The Royal College of Paediatrics and Child Health • Department of Health and Social Care • The National Institute for Health and Care Excellence Copied for interest to: • Chief Coroner • Manchester University NHS Foundation Trust • Next of kin
1	**CORONER** I am Zak Golombeck, Her Majesty's Area Coroner for Manchester (City)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** I concluded the inquest into the death of **Michael Chahwanda** on 13th January 2021 and recorded that he died from: 1a Circulatory failure following out of hospital cardiac arrest 1b Cardiomyopathy associated with Vitamin D deficiency
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was born on 19th September 2018 and died at Royal Manchester Children's Hospital on 16th December 2018. The cause of his death was associated with a severe deficiency in Vitamin D. The Deceased (and his mother) had increased skin pigmentation. The Deceased's mother was advised to take Vitamin D in the ante-natal period; however, she was not advised to take supplements in the post-natal period, even though she was at a higher risk of Vitamin D deficiency as a result of her increased skin pigmentation and that she was breast-feeding. On 16th December 2018 the Deceased suffered a seizure at home and wad admitted to hospital. He had no respiratory or heart rate, and showed signs of hyperkalaemia and hypocalcaemia. He died at the hospital on the same day.

	At the Inquest, held on 13th January 2021, I explored the national guidance on Vitamin D supplementation, together with the contents of 'My Personal Child Health Record' (commonly referred to as 'The Red Book'). The latter makes no reference to Vitamin D supplementation advice being provided to mothers. The only reference to Vitamin D supplementation is an advert from a national charity, although this does not refer to specific advice. Moreover, I explored the issue of provision of Vitamin D supplements to mothers, and the cost-effective of this. I heard evidence from a leading Consultant in Paediatric Bone Disease, who told me that the national guidance provides advice to mothers, whereas it should be a directive for mothers to take Vitamin D. In addition, the evidence from the Consultant was that it would be cost-effective for the National Health Service to provide Vitamin D supplements to mothers and breast-fed babies. The Consultant highlighted the fact that breastmilk does not contain Vitamin D as of crucial importance.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. To The Royal College of Paediatrics and Child Health and Department of Health and Social Care and The National Institute for Health and Care Excellence: To consider an amendment to the Red Book to include specific advice for Vitamin D supplementation in the postnatal period to be given by the attending Health Visitor. Such advice would be consistent with national guidance. 2. To Department of Health and Social Care and The National Institute for Health and Care Excellence : To consider an amendment to the guidelines so that there is a directive for women (particularly those with an increased skin pigmentation and those who are breast-feeding) to take Vitamin D supplements. Also, to consider the provision of Vitamin D to women and babies who are at an increased risk of Vitamin D deficiency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **Monday 29 March 2021**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to Interested Persons. I have also sent it to organisations who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE:** 27th January 2021 **NAME OF CORONER:** Mr Zak Golombeck HM Area Coroner for Manchester City Area **Signed:**