REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) [redacted], Chief Executive,** **National Institute for Health and Care Excellence** **10 Spring Gardens** **London** **SW1A 2BU**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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	**INVESTIGATION and INQUEST** Naiya Diarra died on 25 June 2015, aged 9 months old, from dilated cardiomyopathy, arising from severe Vitamin D deficiency. An inquest into her death was heard on 30 October 2015, at which I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Naiya was not known to have developed the severe Vitamin D deficiency, from which she ultimately died. I heard evidence that vitamin supplementation was discussed with her mother and instituted through her mother taking additional dietary vitamins and later through use of additional formula feeding. However, it is clear that this was ultimately insufficient to prevent her death. Her sibling was known to be Vitamin D deficient and I saw evidence that health visitors had attended the family home regarding this and had given advice regarding sunlight exposure in particular. However, the significance of her sibling's deficiency was not recognised by those treating Naiya and I concluded that there was missed opportunities to address this. I heard evidence that NICE guidance exists regarding the identification and treatment of Vitamin D deficiency
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) Multiple pieces of relevant information regarding [redacted] current illness were

	contained in disparate record 'silos'. It was difficult for clinicians to access this information and, as such, it was not available to the reviewing psychiatric team, in particular. I am concerned that the previous focus on access to medical records, which was to occur through the NHS Programme for IT, has been lost and that the new focus on patient access to GP records will not address the risks posed by the current state of record sharing within the NHS.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressee, has 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 by 2 December 2015. 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, [redacted] family, [redacted] GP and the three NHS Trusts involved. 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	**7 October 2015** **Assistant Coroner R Brittain**