[redacted]

BMA

[redacted]
Office of the Coroner

Sent via email
8th July 2024

Dear [redacted],

GPC England acknowledges the tragedy of this case and the unique chain of events, stretching back many years, that led to the death of Mr Reid, ultimately due a rare and unpredictable side effect of the Oxford AstraZeneca vaccine. The data entry error where Mr Reid's weight was incorrectly entered informed the decision by NHS England to invite Mr Reid for vaccination earlier than his age category would have indicated. Had this error not been present it is likely Mr Reid would have been invited for his vaccination at a different time, when more might have been known about the side effects of the different vaccines which were available, and the outcome may have been different. It could not have been predicted at the time the data entry error was made that there might one day be a future pandemic that would necessitate a vaccination strategy that made use of the weight that had been erroneously entered. It is important for patient trust that medical records are accurate, and that any clinical decisions made based on recorded information are appropriate. If trust is damaged and patients become reluctant to make use of vaccination programmes there is the likelihood of future harm, through illness and possibly death, that might otherwise have been avoided.

With regard to the matters of concern, we propose to discuss these at our next Joint GP IT Committee meeting (which has representatives of the BMA, RCGP and the NHS) to raise awareness of this case and seek a consensus on how systems might evolve to reduce the likelihood of similar data entry errors in the future. Given the complex chain of events of this particularly tragic case, where any one step, had it been different, might have led to a different outcome, we would propose advocating a way forward that addresses the main identified concerns which will transcend this case, namely that patients must know why they have been offered a given treatment and that the decision is sound based on the prevailing medical understanding at the time. It would seem unlikely that the exact same circumstances of this case would ever occur again, but it is clear improvements can be made in the NHS's IT systems so patients can have greater confidence that they are being offered appropriate treatments that take into account their own unique circumstances.

Yours sincerely,

[redacted]

[redacted]
Co-Chair Joint GP IT Committee