His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield
WF1 2TS

By email: [redacted]

Your Ref: [redacted]

29th April 2024

Dear Mr Longstaff,

Re: Regulation 28 Report to Prevent Future Deaths – Alexander Lee Reid DOD 29/06/2021

Thank you for your Regulation 28 Report dated 18/04/2024 concerning the death of Alex Reid. Firstly, I would like to express my deep condolences to the family and friends of Mr Reid.

I am [redacted], the Clinical Director for TPP, providers of the clinical IT system (SystmOne) currently used by the GP practice that Alex was registered with at the point of his tragic death.

The specific concern raised in your report that is relevant to TPP, as a GP system supplier, is about the validation of data items entered into GP IT systems. In this instance, the erroneous entry was recorded on 06/02/2004. This entry was not made on SystmOne, rather it was made on the GP practice's previous IT system and the data was subsequently migrated to SystmOne when the practice changed IT systems on 01/04/2019.

In SystmOne, there is already validation at the point of entry on height and weight measurements to prevent extreme values being entered. For example, a maximum height of 3 metres can be entered, with the maximum weight being 500 kilograms. Similarly, a calculated BMI is constrained to between 0 and 150. It is not impossible, however, for someone to have a BMI as high as the one that was calculated in this instance. Thus the system must allow such a BMI to be accurately recorded if this is the true calculated BMI.

The death of Mr Reid, sadly, appears to be the culmination of multiple issues, including:

1. The initial error made when entering the data by the system user.
2. The lack of a suitable algorithm to detect when an abnormal BMI calculation (although possible) is unlikely.
3. The extraction of data by NHS Digital (now NHS England) and subsequent processing to detect the at risk population also lacking an algorithm to detect unlikely BMI results.
4. The error not being identified by the GP practice; GPs were asked to check all patients who were flagged as high risk to ensure suitability for vaccination.

[redacted]

5. The vaccinator not having sufficient information at the point of giving the vaccine to recognise the error. The vaccinator probably did not have access to the patient's GP record to see why the high risk flag had been added to the record (N.B. The reason for the patient being marked as vulnerable was included in the message to GPs in around April 2020).

To return to the specific concern that could be directed to GP system suppliers, should NHS England decide that it would be appropriate to include validation concerning the calculation of BMIs in GP IT systems, the requirements for this would be most appropriately set at a national level to ensure a consistent approach across all GPs. Of course, in the clinical environment there are already a number of alerts, flags, prompts and notifications directed at clinical staff, and consideration would need to be taken as to the sensitivity of the validation to ensure this is not triggered so frequently as to cause 'alert fatigue'.

I note that your report has been sent to relevant persons at NHS England but I will also look to make contact with NHS England separately regarding this matter.

Kind regards

[redacted]

[redacted]
GMC: [redacted]