REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Chelsea and Westminster Hospital, 369, Fulham Road, London. SW10 9NH c/o legal [redacted] [redacted] Chief Executive, Great Ormond Street Hospital, Great ormond Street, London. WC1N 3JH c/o legal [redacted]
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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** On 13th and 14th January 2026 evidence was heard touching the death of Ms Sidra Aliabase. She had died at Chelsea and Westminster Hospital on 10th May 2026, aged 3 weeks. **Medical Cause of Death** Ia Iatrogenic hypocalcaemia and long QT Syndrome II Complications of prematurity, pulmonary artery stenosis with right ventricular hypertrophy and intrauterine growth restriction **How, when and where the deceased came by her death.** Sidra was born on 19/4/2024 at Chelsea and Westminster Hospital by emergency caesarean section at 27 weeks and 1 day gestation. She was very small and needed help with breathing and nutrition and was admitted to neonatal intensive care (NICU). She suffered an episode of sepsis in her second week of life.

	Sidra had a 50% chance of suffering with long QT syndrome. This risk had been recognised prenatally but no plan put in place to expedite diagnosis at birth. Expert opinion in relation to long QT was sought from Great Ormond Street Hospital but not adequately communicated back to the team at Chelsea and Westminster Hospital. Sidra was diagnosed with patent ductus arteriosus by the visiting paediatric cardiologist from the Royal Brompton Hospital who also requested an ECG on 30/4/2024. On 8/5/2024, Sidra was wrongly prescribed sodium acid phosphate rather than sodium chloride. This was prescribed at approximately 5 times the recommended dose for a neonate of her size. This mis-prescription and overdose directly led to and caused hypocalcaemia and bradycardia, exacerbated by long QT syndrome, now apparent on ECG. The phosphate was lowered rather than stopped at around 1500, just after a 4th dose had been administered, following contact from the pharmacy. The drug error was not communicated to the consultant at the material time. The hypocalcaemia was apparent on blood gas analysis from approximately 0200 on 9/5/2024, but not recognised by clinicians until approximately 18:20, and corrective treatment started at approximately 19:30. Expert opinion was sought and all treatment given. Despite this, Sidra continued to deteriorate to her death at 00:12 10/5/2024. The failure to prescribe the medication correctly was a failure in basic care and this was compounded by the failure to recognise the hypocalcaemia and the mis-prescribing across multiple shifts and clinical disciplines. **Conclusion of the coroner as to the death:** Accident contributed to by neglect.
4	**Evidence Relevant to the Matters of Concern:** Extensive evidence was taken during the inquest, from the pharmacist, nurses and doctors and the pathologist. Although Sidra's mother had received care from the Royal Brompton Hospital (RBH) and the expert cardiology obstetric team at Chelsea and Westminster(C&W), as she suffered with autosomal dominant long QT, and had 2 elder sisters with the same condition, no plan had been put in place to expedite diagnosis at birth. The team should also have been on notice for the possibility of a premature delivery since both her sisters had been born prematurely. RBH provides an outreach paediatric cardiology service to C&W, with a visiting paediatric cardiologist, but instead of making use of this service, the neonatal team at C&W contacted GOSH for advice as Sidra's sisters were under GOSH, even though GOSH would not likely play an active role until discharge and Sidra was unlikely to be discharged for some time. The GSOH on call paediatric registrar was contacted and gave phone advice including avoiding meds that could predispose to arrhythmia and ensuring electrolyte levels were within the normal range, and to undertake a 12 lead ECG to assist with diagnosis, but did not seek advice re genetic testing nor alert the consultant caring for Sidra's sisters, leaving the onus on C&W to call back. The team at C&W recalled GOSH then emailed the paediatric cardiology consultant directly, who made a suggested management plan, but this was not transmitted to C&W. This led to potential delays in diagnosis and the prescribing of

prophylactic treatment for the risk of tachyarrhythmias (beta blockers) and genetic testing, which were unfortunate, but did not contribute to the death. The court accepted evidence that treatment with beta blockers would not have protected against the subsequent hypocalcaemic induced bradycardia that led to Sidra's death.

A finding was made by the court that it would have been more sensible for C&W to seek advice from the in house RBH team when genetic testing would likely have happened promptly and diagnosis been made earlier, and later transfer to GOSH on discharge if Sidra would have been better cared for at the same hospital as her sisters. As above, this did not contribute to the death but would have reduced the risk of tachyarrhythmias developing in an already very premature and unwell baby.

Overnight 8th to 9th May 2024, Sidra developed progressive hypocalcaemia and bradycardia. The bradycardia was wrongly thought to be due to a change in route of opiate administration by the night team who missed hypocalcaemia and wrong prescribing.

By the morning of 9th May 2024 her bradycardia was worsening, and long QT was grossly apparent on her heart trace monitor.

IV lines and electrolyte blood testing were requested, as electrolyte disturbance can cause or exacerbate arrhythmias and expert advice sought from the RBH. However once more, hypocalcaemia and the prescribing error was missed.

Sidra went on to deteriorate and died as a direct result of the error in prescribing both the incorrect medication and in overdose. (Excess phosphate binds calcium reducing blood levels of calcium and predisposing to bradycardia.) This was exacerbated by the failures to check blood results and prescribing at ward rounds and on administration of the phosphate by nursing staff on the 8th and 9th May 2024, and the failure to escalate hypocalcaemia on blood gas results by the nursing team, such that it was not noticed until 18:20.

The error in prescribing was noted by the pharmacist around 11:30. Attempts were made by the pharmacist to contact the prescribing doctor, and finally communicated to the prescribing doctor at around 14:30. The court accepted the evidence of the pharmacist that they had checked Sidra's records and noted hyponatraemia and suggested to the doctor that sodium chloride should have been prescribed rather than sodium acid phosphate, as well as advising that phosphate had been prescribed in overdose. The prescribing doctor simply reduced the phosphate dose at around 1500 and stated that they chased electrolyte blood test results, which should have been taken on the 8th May and already taken earlier on the 9th May but had not been. The doctor did not look at blood gas results where they could have seen calcium levels, if not phosphate, and did not inform the consultant attempting to manage the bradycardia, nor complete datix.

This led to even more delay in treating the hypocalcaemia and recognising the cause of the bradycardia.

The court found that the effect of phosphate overdose on calcium is something that the prescribing doctor should have been aware of and communicated to the consultant. The fact that the prescribing doctor went on to chase Sidra's electrolyte levels, and retake them their self, after being made aware of their prescribing errors supported this finding. It was not until the morning after Sidra's death that the prescribing doctor informed the consultant of their errors, by which time the consultant was already aware.

	There were thus multiple missed opportunities to recognise the prescribing error and overdose and its effects in a timely fashion that may have improved the outcome for Sidra and prevented her death at the material time. The prescribing doctor described to the court that they had chosen the wrong drug from the drop-down menu. Since this death there has been training of staff around phosphate prescribing and the importance of hypocalcaemia and reporting of prescribing errors which is also now undertaken by the pharmacist if capable of causing moderate harm to the patient. The ward round proforma also now includes a review of medication prescribing and blood test results. Such changes have addressed many of the court's concerns. However, there are still a number of outstanding concerns as listed below.
5	**Matters of Concern** 1. That communications by the on call paediatric cardiology team at GOSH are not as they should be when they communicate between themselves and hospital teams that contact them for advice. 2. That systems for making plans for diagnosing long QT in newborns at risk need to be put in place early in pregnancy in case of premature delivery. 3. That Chelsea and Westminster neonatal doctors should take advice primarily from its in house visiting paediatric cardiology team for babies likely to be in hospital for some time, even if care is later transferred to another hospital service for long term follow up. 4. That drop-down menu prescribing is more likely to lead to errors in drug selection for drugs of similar names.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 the following Interested Persons: [redacted] [redacted] c/o legal team [redacted] 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	**21st January 2026** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**