	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], NaturPlus UK** **2. Food Standards Agency** **3. Department of Health & Social Care**
1	**CORONER** I am JONATHAN STEVENS, Assistant Coroner, for the coroner area of Surrey
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 6th June 2023 Area Coroner Simon Wickens commenced an investigation into the death of DAVID CHARLES MITCHENER [age 89]. The investigation concluded at the end of the inquest on 28th December 2023. The conclusion of the inquest was of death by misadventure.
4	**CIRCUMSTANCES OF THE DEATH** On 10th May 2023 David Mitchener was admitted to East Surrey Hospital with Hypercalacaemia, but despite treatment he died at the hospital on 20th May 2023. Ante-mortem test revealed Vitamin D levels at 380 (the maximum level recordable by the laboratory). A post mortem identified the cause of death to be: 1(a) Congestive cardiac failure and acute on chronic kidney failure (b) Hypercalacaemia (c) Vitamin D toxicity 2. Ischaemic Heart Disease David Mitchener had been taking vitamin supplements for at least the preceding 9 months, purchased from NaturPlus UK. [redacted] [redacted] There were no warnings on or in the packaging detailing the specific risks or side effects of taking Vitamin D supplements.

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 could 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) Vitamin supplements can have potentially very serious risks and side effects when taken in excess (2) Current food labelling requirements do not require these risks and side effects to be written on the packaging. (3) Absence of appropriate warnings and guidance about dosage
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th March 2024. 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 [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	**19th January 2024** **SIGNED**