REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 30th September 2021 I commenced an investigation into the death of Malcolm John Garrett. The investigation concluded on the 16th June 2022 and the conclusion was one of **Narrative: Died from Covid-19 acquired whilst an inpatient contributed to by the complications of a lung transplant**. The medical cause of death was **1a) Covid pneumonitis and pseudomonas aeruginosa bronchopneumonia; II) Chronic immunosuppression (lung transplant 2013), chronic allograft dysfunction/bronchiolitis obliterans, non-traumatic thoracic vertebra wedge fracture, ischaemic heart disease, chronic kidney disease.**
4	CIRCUMSTANCES OF THE DEATH Malcolm John Garrett had a bilateral lung transplant in 2013. He was placed on long term medications to avoid rejection of the transplant. He was immunosuppressed as a consequence. He also developed chronic allograft dysfunction and chronic kidney disease and ischaemic heart disease that are recognised long term complications in transplant patients. He developed severe back pain and was admitted to Stepping Hill Hospital on 2nd August 2021. A MR of the spine showed a traumatic wedge fracture of the vertebra at T9. He was given pain relief and subsequently fitted with a brace. On 7th August 2021 he had symptoms of opiate toxicity and was treated with opiate reversing medications. The

	toxicity was probably as a consequence of an acute kidney injury. He was found to have developed pneumonia and was treated for it. He was placed on NIV due to ongoing acidosis. Subsequently he was stabilised and was weaned off NIV. On 8th September he deteriorated significantly and was again started on NIV and intravenous antibiotics. He stabilised again. Subsequently on 17th September 2021 he began to deteriorate again. Antibiotics were restarted as he showed signs of infection. On 19th September 2021 he was confirmed to be Covid-19 positive having acquired it whilst in the hospital. He was moved to a Covid ward and treated. He subsequently deteriorated further and died at Stepping Hill Hospital on 23rd September 2021. Post-mortem examination confirmed the direct cause of his death was a combination of Covid pneumonitis and pseudomonas aeruginosa bronchopneumonia.
5	<u>CORONER'S CONCERNS</u> 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. The Inquest heard that it was recognised that Mr Garrett was at high risk of acquiring Covid-19 in a hospital setting as he was immunosuppressed following his transplant. Despite the risk being recognised he still acquired Covid-19. The Inquest heard that all such patients are at high risk in an acute hospital setting but there is no specific guidance for their management; 2. The evidence before the inquest was that Mr Garratt needed to be discharged as quickly as possible to reduce the risk of acquiring Covid-19. However there was no specific guidance about expediting patients such as him and looking at alternative methods of treatment; 3. His discharge was delayed in part due to opiate toxicity. That arose as a consequence of his kidneys not functioning correctly. The inquest heard evidence that to avoid opiate toxicity is such situations there needs to be a greater use of and understanding of the importance of monitoring kidney function.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 **29th September 2022**. 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 namely [redacted] on behalf of the Family and Stepping Hill Hospital, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **04.08.22**