

IN THE WEST YORKSHIRE (EASTERN) CORONER AREA

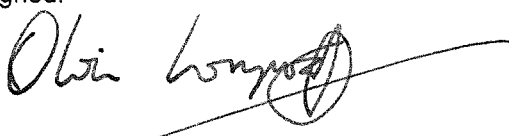
HM AREA CORONER OLIVER LONGSTAFF

IN THE MATTER OF ALEXANDER LEE REID

REPORT TO PREVENT FUTURE DEATHS

	<p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED], Chief Medical Officer EMIS2. [REDACTED], Chief Medical Officer TPP3. [REDACTED], Chief Clinical Information Officer, Vision & Cegedim4. Joint GP IT Committee, BMA and RCGP5. [REDACTED], Medical Director for Primary Care NHS England6. [REDACTED], Chief Information Officer, NHS England7. [REDACTED], National Chief Clinical Information Officer, NHS England8. The Digital Safety Team at NHS England
1	<p>CORONER</p> <p>I am Oliver Robert Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern).</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 14th July 2021 I commenced an investigation into the death of Alexander (Alex) Lee Reid, 22/12/1992. The investigation concluded at the end of the Inquest on 10/11/2023. The conclusion of the Inquest was a narrative conclusion reflecting Alex's death being linked to his having received the Oxford Astra Zeneca vaccination against Covid-19, the medical cause of death being 1a) Cerebral Venous Sinus Thrombosis 1b) Covid-19 Vaccine-Induced Immune Thrombotic Thrombocytopenia.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Alex was invited to receive his Covid vaccination earlier than his age alone would have entitled him to do so. Alex received his first dose of the Oxford Astra Zeneca vaccine on 21/03/2021. On 07/04/2021, official advice was given that persons aged under 30 should not receive the Oxford Astra Zeneca vaccination as their first vaccination. Those who had by that date received it as their first vaccination were advised to receive it as their second. Alex did so on 18/05/2021. He died on 29/06/2021. He was 28.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:-</p> <p>(1) When Alex was invited to receive his vaccination early, he did not understand</p>

	<p>why, and no-one was able to tell him.</p> <p>(2) The inquest heard expert evidence that the combined vaccination monitoring and recall specification designed to identify vulnerable people for the purposes of inviting them to receive their Covid vaccinations early had identified Alex as vulnerable from an incorrect BMI of 68.97 recorded in his GP records on 06/02/2004. The mistake was due to the relevant clinician recording Alex's height as 145cm and his weight as 145kg, giving a BMI of 68.97 for an 11 year old boy whose previously recorded BMI aged 9 had been 14.88.</p> <p>(3) The inquest heard expert evidence that to have built a system that would validate multiple data items in an individual's GP records for the purposes of ensuring that individuals were not incorrectly identified as vulnerable would not have been feasible within the constraints and context of the Covid-19 programme.</p> <p>(4) The inquest heard expert evidence that an easier and more appropriate option would be to embed validation rules in general practice IT systems that would check such information at the time of data entry.</p> <p>(5) If the obviously erroneous BMI had not been recorded or had been challenged at the point of entry by the relevant IT system, Alex would not have been classed as vulnerable, would not have been offered a vaccine before guidance was published that the under 30's should not receive the Oxford Astra Zeneca vaccine, and would not have died when he did.</p> <p>(6) The consequences of the data input error in this case give rise to a concern that more might be done by way of specification design to allow for the correction of or challenge to potential data input errors at the point of entry, with consequential improvements in the reliability of such data and the safety of patients and reducing the risk of other deaths occurring in similar circumstances in the future.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you or organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14/06/2024. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [REDACTED]. I have also sent it to [REDACTED] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> <p>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.</p>

9	<p>Signed:</p>  <p>OLIVER LONGSTAFF Area Coroner West Yorkshire (E)</p> <p>Date: 18 April 2024</p>
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