IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Peter Clive HIGSON
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Frimley Park Hospital NHS Trust Blood Transfusion Service Secretary of State for Health
1	**CORONER** Michael Burgess Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 28th March 2013 I opened the inquest into the death of Peter Clive HIGSON, who at the date his death was 63 years old. The inquest was resumed and concluded on 23 October 2013. I found that the cause of death to be: 1a – Myocardial Infarction 2 – Acute Respiratory Distress Syndrome & Treated Hodgkin's Disease The inquest concluded as follows: **That the deceased died from a complication of a necessary therapeutic procedure**
4	**CIRCUMSTANCES OF THE DEATH** The deceased had suffered from Hodgkin's lymphoma. On 29th Janaury 2013 he underwent an autologous stem cell transplant at University College Hospital, London after which he was discharged home. On 28th February 2013, he became very unwell and was admitted to Frimley Park Hospital and was treated for Pneumocystis Jiroveci Peneumonia with a 21 day course of Co-Trimoxazole and with Methylprednisolene. His chest remained an issue, however, and he underwent a platelet

	transfusion of 2 pools of platelets on 12th and 13th March which made matters worse. His clinical situation looked like a transfusion related acute lung injury which had a detrimental effect on his breathing and overall well-being. He slowly improved but towards the end of the Co-Trimoxazole course, it was learnt that he did not have the Pneumocystis infection. He died on 22 March 2013 The family praised the doctors and support staff at both University College Hospital, London and Frimley Park Hospital.
5	**CORONER'S CONCERNS** The platelet transfusion (12 & 13th March 2013) following the stem cell transplant (28th January 2013, seemed to have a major detrimental effect on the deceased and features, if only chronologically, in the ultimate chain of causation leading to his death. A question arises as to whether there was any aspect of e.g., the stem cell transplant interacting with the platelet transfusion suggesting that on occasions such transfusion might be contra-indicated.
6	**ACTION SHOULD BE TAKEN** In my opinion a review of the various issues might inform future treatment.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • [redacted] • [redacted] Consultant Haematologist (Frimley Park Hospital) • Chief Coroner
9	**Signed: Michael Burgess, HM Assistant Coroner for Surrey** **DATED this 24th day of October 2013**