REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Leeds Teaching Hospitals NHS Trust** 2. **Reed Nursing Agency**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (East).
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 4 March 2020 I commenced an investigation into the death of Macloud Nyeruke, aged 65. The investigation concluded at the end of the Inquest on 15 September 2020. The Inquest concluded that the death was attributable to natural causes based on the following medical cause of death: Ia Sepsis due to multi-drug resistant Pseudomonas, Morganella and E Faecium Infections Ib Ic II Multi-drug resistant tuberculosis, Human Immunodeficiency Virus
4	**CIRCUMSTANCES OF THE DEATH** Macloud Nyeruke came to the UK from Zimbabwe in 2002. He worked in various hospitals as a support worker, having been placed by a nursing agency. His medical history included tuberculosis and a HIV infection diagnosed in 2004. On 23 November 2019 he was admitted to hospital with a fever, cough and confusion. He remained in hospital until his death on 22 February 2020. Extensive investigations revealed he had a strain of TB which was resistant to antibiotics and had developed multidrug-resistant bacteria.
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 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) Mr Nyeruke's medical conditions were not made known to the Trust. In consequence, he had worked on wards where patients had infections involving multi-resistant organisms. Given his compromised immune state, this situation involved risk to both patients and Mr Nyeruke himself. In the absence of information concerning a particular staff member's medical condition there is an increased risk of transmission of infections either to or from the staff member.

	(2) There is scant evidence as to whether Mr Nyeruke underwent appropriate training in respect of PPE such as masks before being permitted to work on a ward involving infectious diseases. The difficulties involved (where a support worker supplied by a nursing agency is only in the hospital for a brief period) are acknowledged. Nonetheless, the risk of an adverse transmission of infection either to, or from, the staff member necessitates stringent standards being enforced, with appropriate records preserved. (3) Nursing agencies which supply support workers to hospitals without knowledge of their particular health vulnerabilities, or where they will be working, give rise to a risk that they may be adversely affected or may give rise to adverse effects on patients or colleagues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 25 November 2020. 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: (1) Ms [redacted] (2) The Secretary of State for Health, Matt Hancock 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	**SIGNED BY SENIOR CORONER, KEVIN MCLOUGHLIN** Kevin McLoughlin **18 September 2020**