REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **NHS England & Secretary of State of Health**
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 8th February 2021 I commenced an investigation into the death of Clive Edward Rivers. The investigation concluded on the 28th May 2021 and the conclusion was one of Died from Covid-19 caught whilst an inpatient at Tameside General Hospital and receiving immunomodulatory therapy prescribed for his skin condition. The medical cause of death was 1a Covid-19 on a background of immunomodulatory treatment; II Seborrheic eczema, Peripheral Vascular Disease

4	CIRCUMSTANCES OF THE DEATH Clive Edward Rivers was admitted to Tameside General Hospital having fallen at home. Whilst an inpatient the dermatologist put him on methotrexate for his skin condition and requested for him to be vaccinated against Covid-19 due to his increased risk of contracting Covid-19. This did not happen due to it not being policy to vaccinate inpatients. He contracted Covid-19 in hospital whilst awaiting discharge. He was discharged home to sheltered accommodation with a care package and a requirement to isolate. He deteriorated with Covid-19 on his return home. He died at his home address, [redacted], Grange House, on 5th February 2021.

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. Clive Rivers was vulnerable to Covid-19 by reason of his age but had to go into hospital as a result of a fall. He had a longstanding skin condition that caused him a great deal of distress and discomfort. Whilst an inpatient he was prescribed immunomodulatory therapy and the consultant dermatologist wanted him to be vaccinated due to the increased risk Covid-19 presented to him both in terms of catching it and being able to recover from it. The inquest was told that whilst vaccines were available on the hospital site, they were at that time due to NHS policy only for staff not inpatients. Therefore, Mr Rivers was not vaccinated. 2. He tested negative for Covid-19 at the point he was medically optimised for discharge however delays in discharge planning including the required assessment under the Right to Reside policy meant that whilst awaiting discharge he contracted Covid-19. 3. The inquest heard that when he was discharged from hospital, he was known to have Covid-19. He was assessed under the national right to reside policy and it was deemed under that policy that he should be discharged back to sheltered accommodation where he would have to self-isolate with carers coming in at set points in the day to support him. He was found deceased by his carers after being left alone. The assessment framework did not appear to take into account his vulnerability to a rapid decline from Covid-19.

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 7th August 2021. 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](family of deceased), 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	**10th June 2021**  **Alison Mutch HM Senior Coroner Manchester South**