REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS • THIS REPORT IS BEING SENT TO: **NHS England**
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 9th November 2020 I commenced an investigation into the death of Roger Phelps. The investigation concluded on the 27th August 2021 and the conclusion was one of narrative- Died from sepsis contributed to by endocarditis not diagnosed until after his death in combination with Covid-19 contracted whilst an inpatient at Tameside General Hospital. The medical cause of death was 1a Sepsis 1b Endocarditis and Covid-19 infection II Congestive cardiac failure, hypertension, type 2 diabetes mellitus, aortic stenosis with left ventricular hypertrophy
4	CIRCUMSTANCES OF THE DEATH Roger Phelps was seen at Tameside General Hospital on 4 occasions in October 2020 with deteriorating cardiac function. He was not referred on the acute heart pathway. Following his admission on 21st October it was recognised that he needed to be treated in the Heart Unit. A bed was not available, and he stayed on a general medical ward until 29th October. He had signs of significant cardiac failure. He contracted Covid-19 from another patient. At the time the trust were swabbing in accordance with PHE guidance. The results of the swabs were regularly taking in excess of 48 hours which increased the risk of exposure in patients to Covid-19. A swab of 29th October reported on 1st November indicated he had Covid-19. He deteriorated rapidly from 29th October. The Covid-19 exacerbated his underlying conditions including his cardiac failure. He exhibited signs of sepsis. He was treated but continued to deteriorate and died at Tameside

	General Hospital on 4th November 2020. Post-mortem examination found he had died from sepsis. He was found at post-mortem to have developed endocarditis which also contributed to his death.
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. – The inquest heard that whilst the trust were following PHE/NHS guidance in relation to regularity of swabbing of inpatients it was regularly taking in excess of 48 hours for swab results to be returned to the trust. The impact of the delay was that infectious asymptomatic patients were remaining on non Covid wards for some days and spreading infection to other patients. The trust where Mr Phelps was a patient had now resolved the issue of delay of results by buying additional on-site testing machines and results were back within hours rather than days. It was unclear from evidence given at the inquest whether the issue of delayed results had been addressed by other trusts in a similar way or if the risk remained to other patients in other trusts.
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 2nd November 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 to the deceased) and Tameside General 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	**7th September 2021**  **Alison Mutch** **HM Senior Coroner Greater Manchester South**