ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health** **2. NHS England** **3. BMI Hospital Thornbury** **4. Sheffield Teaching Hospitals NHS Foundation Trust** **5.** [redacted]
1	**CORONER** I am Raymond Frederick Curtis, Assistant Coroner, for the coroner area of South Yorkshire (East District).
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 18th April 2013 I commenced an investigation into the death of Peter John Hinchliffe aged 33 years. The investigation concluded at the end of the inquest on 27th May 2014. The conclusion of the inquest was that the cause of death was 1a) Arrhythmogenic right ventricular cardiomyopathy, with a narrative conclusion as follows:- Peter John Hinchliffe a fit 33 year old man suffered a episode of syncope in May 2010 whilst cycling following which he sought advice and was the subject of certain investigative procedures all of which had not been completed by the time of his death following a collapse, again whilst cycling on 11 September 2010. His death arose from a natural condition which was undiagnosed and untreated. Had he desisted from anything other than very basic exercise it is more likely than not that his life would have been prolonged in the short term. Further had the full investigative process sufficient to diagnose his condition been completed with greater expedition he could have anticipated a reasonable expectation of life.
4	**CIRCUMSTANCES OF THE DEATH** Peter John Hinchliffe was a fit young man, self employed as a personal trainer, and a cyclist who had reached a high competitive standard during his career. Immediately prior to his death he was no longer competing frequently and was involved in leisure cycling covering reasonable distances. He had an episode of palpitation in 2006 which was investigated and a more serious event of syncope in May 2010 whist out cycling. He blacked out for some 20 to 30 seconds. Subsequently he consulted his GP and was referred to [redacted] at the BMI Hospital Thornbury where he was seen on the 15th of June 2010 and on that date he had a resting ECG and an exercise stress test.

	Arrangements were made for echocardiography undertaken on the 23rd June 2010 at the Hallamshire Hospital. He was seen again on the 29th of June 2010 by which time it was considered that there was nothing diagnostic of ARVC although subsequently there was differing professional opinion on interpretation of the initial ECG. Thereafter arrangements were made for a cardio-memo recording which was delayed and although other investigative processes were contemplated none were undertaken prior to his death. There was a further review on the 24th of August 2010 when [redacted] was continuing to express concern. At this time arrangements were made for further investigative processes to be carried out in the National Health Service as these investigations could not be carried out at BMI Thornbury Hospital. In particular the implantation of a loop recording device for which he was placed on a waiting list and magnetic resonance imaging were contemplated. It was also intended to discuss his case at an MDT meeting in early September 2010 prior to further investigative procedures. In the event this meeting was cancelled and the next meeting at which discussion of his case would have taken place was on the 6th of October 2010. In the meantime Peter John Hinchliffe suffered a further collapse whilst cycling on the 11th of September 2010 and despite prompt attention he was pronounced dead at the Doncaster Royal Infirmary. Throughout it was acknowledged that syncope was a red flag prompt. Although he was advised to avoid rigorous exercise/competitive cycling the extent of acceptable activity was not further defined and professional opinion as to the level of acceptable activity by a fit young man in the known circumstances differed. Initially the Coroner ordered a post mortem examination which revealed a natural cause and the death was dealt with without inquest. Subsequently Peter John Hinchliffe's father a retired General Practitioner asked that an inquest be opened to which the Coroner acceded and the inquest was opened on the 18th of April 2013.
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) All investigative procedures could not be undertaken privately and transfer to the National Health Service was necessary to complete investigations. (2) In the private sector there was delay initiating investigative procedures after the consultation on 29th June 2010. (3) Although Peter John Hinchliffe died approximately two weeks after transfer into the NHS system no further progress would have been made until after the MDT meeting in early October some 4 – 5 months after the incident of syncope. (4) Evidence revealed significant differences in the times and routes taken to undertake investigative procedures in cases where there is a differential diagnosis including ARVC. (5) The evidence revealed inconsistencies of approach in advice to fit young athletes as to future exercise in what was generally acknowledged to be a 'red flag' situation. (6) Whilst there has been greater awareness since 2010 both locally and nationally of the need for timely and appropriate management of syncope in young athletes the approach to the problem does not appear to be consistent nationally and there is a continuing need to emphasise and act on this issue.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and or your organisation 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 12th August 2014. 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. [redacted] 2. I have sent a copy of my report to the General Medical Council and to Cardiac Risk in the Young. 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	**[DATE]** **[SIGNED BY CORONER]**