	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chair of the CHD Review's Clinical Advisory Panel** **2. [redacted] Chair of the Congenital Heart Services Clinical Reference Group** **3. [redacted] Programme Director for the CHD Review** **4. [redacted], Director of the East Anglia Team**
1	**CORONER** I am Dr Peter Dean, senior coroner for the coroner area of Suffolk
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 the 18th of May 2012 I commenced an investigation into the death of Samuel James Openshaw, aged 15 months. The investigation concluded at the end of the inquest on the 23rd of May 2014. The conclusion of the inquest was Natural causes, the cause of death being 'Complex congenital heart defect (operated)'. Although, from the pathological findings, this tragic death appears to have arisen from acute on chronic failure of the operated heart, there were matters that became evident which gave cause for concern, affected the clinical management as discussed below, and which could affect the outcome for other children.
4	**CIRCUMSTANCES OF THE DEATH** Samuel was born with serious and complex heart problems and had been under the care of both the Evelina Children's Hospital, where he had undergone an initial operation followed by very major cardiac surgery, and the West Suffolk Hospital where ongoing paediatric care was provided. He presented at the West Suffolk Hospital with further clinical problems and his condition deteriorated. Transfer back to the Evelina Hospital was arranged but delays with the specialist paediatric retrieval teams, who were still engaged on other transfers, meant that Samuel was only admitted to their paediatric intensive care unit more than twelve hours after the initial referral from the West Suffolk Hospital, and he sadly passed away hours later. The situation was made more tragic by the fact that there were difficulties with the secure electronic transfer of echo images from the West Suffolk to the Evelina Hospital and that, had the Evelina been able to receive this information, it is likely that the decision would have been made to keep Samuel at the West Suffolk Hospital for palliative care, thus avoiding the very considerable distress to Samuel and his family of the events of that last day.
5	**CORONER'S CONCERNS** During the period of investigation and inquest, a number of other issues also became apparent but I have not touched on these in this report as they were matters related to the local hospital and I am satisfied that action has been taken to address them. I am, however, concerned that, despite undoubted attempts to remedy the problem, slow electronic transfer of Echocardiograph studies to tertiary centres remains a problem and one that may affect other hospitals as well. There were also clearly difficulties with the workload that the specialist paediatric retrieval teams were working under. While the evidence here, sadly, was that even had earlier transfer to the paediatric intensive care unit at the tertiary centre been achieved, the tragic outcome would have been the same in this instance, the availability of these specialist retrieval teams for urgent patent

	transportation and the need to be able to transfer electronic images in a secure and timely manner, are issues that could affect the survival of sick children in other areas and are matters requiring the involvement of those who commission healthcare services themselves. I am therefore writing to you to ask that attention be given to this to try to reduce the risk of similar fatalities in future.
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 the 15th of August. 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, to Samuel's family, and to West Suffolk Hospital Consultant Paediatrician [redacted] 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	**20-6-14** P D Dean **Dr Peter Dean**