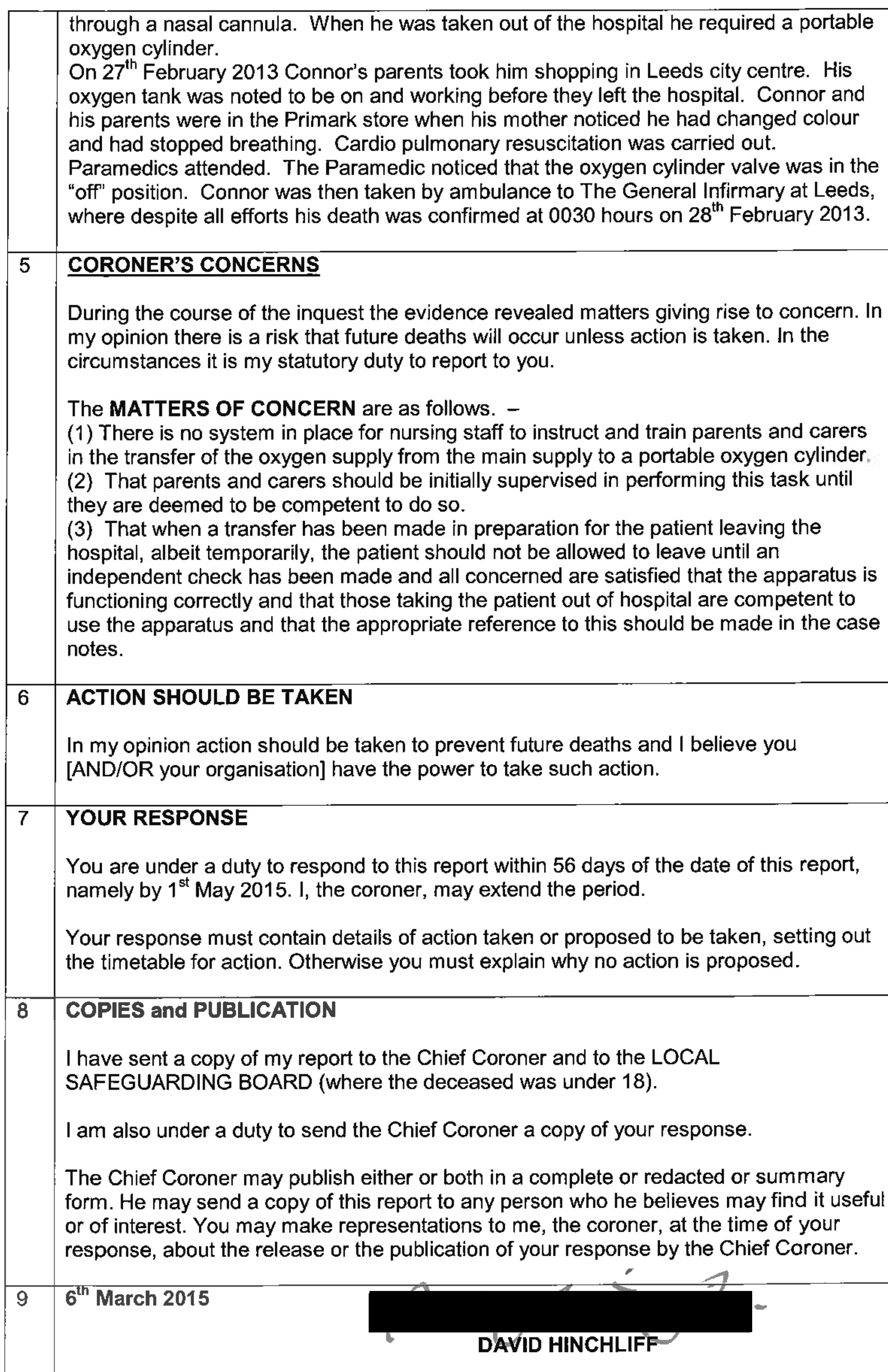
ANNEX A

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. [redacted] Medical Director of the Leeds Teaching Hospitals NHS Trust, Trust Headquarters, St James's University Hospital, Beckett Street, Leeds, LS9 7TF**
1	**CORONER** I am David Hinchliff, 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 28th February 2013 I commenced an investigation into the death of Connor Adrian Turner, aged three months. The investigation concluded at the end of the inquest on 2nd February 2015. The cause of death being :- 1(a) Unascertained and 2. Cystic fibrosis with previous laparotomy for meconium ileus and previous corrective surgery for congenital cardiac anomaly. The conclusion of the inquest was :- Connor Adrian Turner was born on 14th November 2012 with cystic fibrosis and a congenital heart defect which was repaired on 14th January 2013. Connor subsequently developed cardiac arrhythmias and a paralysed right hemidiaphragm. Connor also suffered reflux and possible aspiration. He suffered recurrent chest infections. He was oxygen dependent and required an oxygen supply via a nasal cannula and cylinder. The cause of death could not be established. Between 15:20 and 17:00 hours on 28th February 2013 Connor was not supplied with oxygen from the cylinder. The poor response to resuscitation, profound acidosis and high lactate and the severity of the damage sustained are all compatible with a hypoxic induced cardiorespiratory arrest. Connor's observations would suggest that he did not have an acute respiratory infection. It is unlikely that reflux and aspiration were the cause of the cardiorespiratory arrest. On the balance of probabilities the cause of death could not be established but the lack of oxygen was a contributory factor. Connor Adrian Turner died on 28th February 2013 at The General Infirmary, Leeds at 00:30 hours.
4	**CIRCUMSTANCES OF THE DEATH** Connor Adrian Turner was born on 14th November 2012 with cystic fibrosis and a meconium ileus. The latter condition was operated on on numerous occasions, the last of which was on 30th January 2013. Connor had a large ventricular septal defect and patent ductus arteriosis and an overarching aorta which was repaired on 14th January 2013. This baby also suffered from reflux and aspiration and was fed with a nasogastric tube. Connor was recovering from Pseudo Bartas syndrome and required oxygen



	through a nasal cannula. When he was taken out of the hospital he required a portable oxygen cylinder. On 27th February 2013 Connor's parents took him shopping in Leeds city centre. His oxygen tank was noted to be on and working before they left the hospital. Connor and his parents were in the Primark store when his mother noticed he had changed colour and had stopped breathing. Cardio pulmonary resuscitation was carried out. Paramedics attended. The Paramedic noticed that the oxygen cylinder valve was in the "off" position. Connor was then taken by ambulance to The General Infirmary at Leeds, where despite all efforts his death was confirmed at 0030 hours on 28th February 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) There is no system in place for nursing staff to instruct and train parents and carers in the transfer of the oxygen supply from the main supply to a portable oxygen cylinder. (2) That parents and carers should be initially supervised in performing this task until they are deemed to be competent to do so. (3) That when a transfer has been made in preparation for the patient leaving the hospital, albeit temporarily, the patient should not be allowed to leave until an independent check has been made and all concerned are satisfied that the apparatus is functioning correctly and that those taking the patient out of hospital are competent to use the apparatus and that the appropriate reference to this should be made in the case notes.
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 1st May 2015. 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 LOCAL SAFEGUARDING BOARD (where the deceased was under 18). 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	**6th March 2015** **DAVID HINCHLIFF**