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] Chief Medical Officer, Trust Headquarters, St James's University Hospital, Beckett Street, Leeds, LS9 7TF** **2.** **3.**
1	**CORONER** I am Philip Anthony Holden, Assistant Coroner for the Coroner area of West Yorkshire (Eastern)
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 24th June 2013 an investigation into the death of Max James Haigh was commenced. The investigation concluded at the end of the Inquest on 5th February 2016. The conclusion of the Inquest was a Narrative Conclusion, the medical cause of death being 1(a) Multiorgan failure (due to heart failure), (b) Cardiomegaly with myocardial fibrosis and lymphocytic myocarditis and (2) Previous cardiac surgery for complex congenital cardiac anomaly and pulmonary regurgitation.
4	**CIRCUMSTANCES OF THE DEATH** 1. Max Haigh was born 11th April 2012. 2. He had a complicated cardiac defect, including a double outlet right ventricular septal defect, pulmonary stenosis and a left sided superior vena cava to the left atrium. On 18th March 2013 he underwent surgery and an unsuccessful attempt was made to perform a double ventricular repair. (In the event a pulmonary band was fitted). The surgery was performed competently. 3. He was discharged from hospital on the 11th April 2013 and his subsequent recovery was unremarkable before he presented to hospital on the 9th June 2013 with a history of vomiting and being unwell. 4. He remained in hospital until the 12th June 2013 when his condition deteriorated. Attempts at resuscitation were unsuccessful and death was pronounced at 2310 hours on 12th June 2013. 5. At post mortem significant findings were that he had multiple organ failure, an enlarged heart (cardiomegaly), myocardial fibrosis and lymphocytic myocarditis.
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) Following surgery the surgeon prepared a note of his operation for the medical records. It was anticipated that Max may, in the future, require further surgery. The note of the surgery was unsatisfactory and failed to set out:- (a) The position of the ventricular septal defect ("VSD") and how it was enlarged; (b) A full description of the VSD; (c) The position of the tricuspid valve; (d) The techniques that were used by the surgeon himself. (2) There is a real concern that any other surgeon performing surgery in the future faced with inadequate surgical notes would be deprived of potentially vital information to assist in the forthcoming surgery.
	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 (26th April 2016). 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: [redacted] of Messrs Michelmores Solicitors, [redacted] of Messrs DAC Beachcroft LLP Solicitors 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	**[DATE]** Jop Philip Hinchcliff - **1 March 2016** **DAVID HINCHLIFF**