**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Leeds Teaching Hospitals NHS Trust** |
| 1 | **CORONER**<br><br>I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 27th March 2015 an investigation was commenced into the death of Adam Alexander Bojelian, aged 15.The investigation concluded at the end of the Inquest on 3rd February 2020.The conclusion of the Inquest was natural causes.<br><br>The medical cause of death was:<br><br>1a Multiorgan failure<br>b Multiagent infection: Enterococcus faecium, Serratia marcescens and Candida sp<br>c Quadriplegic cerebral palsy |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Adam Alexander Bojelian suffered a severe birth injury and was profoundly disabled due to quadriplegic cerebral palsy, epilepsy, chronic lung disease and other conditions.<br><br>He was admitted into hospital in September 2013 and remained in hospital for some 17 months until taken to a hospice on the eve of his death on 24/03/15.<br><br>His parents were concerned at the quality of his care in the hospital and pressed for him to be admitted to a paediatric intensive care unit (PICU). The treating doctors did not consider this was required until 25/02/15, when he was transferred to PICU. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>**(1) Training Records for Nurses.**<br>The evidence revealed that in 2015, the Trust did not hold records of the training received by individual nurses. Instead, it was left to each individual nurse to maintain their own training records. |

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| | The concern arising from this is that, without accurate records, a Trust cannot be sure a particular nurse has the required skills and competence to carry out a particular task. Instances of this revealed at the Inquest was whether nurses on ward 40 at LGI had received training in relation to Bair Huggers or BiPAP ventilation equipment used in the care of critically ill children.<br><br>**(2) Formal Written Care Plans**<br>The evidence taken at the inquest revealed that despite the complex medical needs of this child, no formal written care plan was created for the period he was in hospital, from September 2013 to January 2015 (15 months). It was assumed all the clinicians involved would glean sufficient information from a review of his notes.<br><br>The absence of a plan meant that aspects of his treatment were not exposed as being controversial (and disputed by his parents). An example of this related to hydrocortisone therapy.<br><br>In complex cases, a comprehensive care plan would provide both parents and clinicians with a basis upon which to obtain a second opinion from an independent source in the event of a dispute, as occurred repeatedly in this case. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 6th April 2020. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to the Parliamentary and Health Service Ombudsman Millbank Tower, 30 Millbank, London SW19 4QP and [redacted], who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **5th February 2020** Kevin McLaughlin |