	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executives of the Sheffield Teaching Hospital Trusts NHS Foundation Trust and the Sheffield Children's NHS Foundation Trust**
1	**CORONER** I am Steve Eccleston Assistant Coroner for South Yorkshire West
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18 September 2023 I commenced an investigation into the death of Craig John BURFIELD. The investigation concluded at the end of the inquest on 26.03.24. The conclusion of the inquest was Craig Burfield died on 24.02.23 at the Northern General Hospital Sheffield from the consequences of clots which formed in his hydrocephaly shunt and cerebral sinus during surgery related to his spina bifida. This caused his brain to swell in an unsurvivable event. The cause of the blood clots could not be established on the evidence. 1a Cerebral oedema and Coning 1b Cerebral Sinus and Ventriculo-Cardiac Shunt Thrombosis 1c Spina-Bifida (Previously treated) II
4	**CIRCUMSTANCES OF THE DEATH** Craig Burfield suffered from spina bifida and had shunts fitted as a child. He had complicated medical needs as a result of his condition. He was admitted for surgery for bladder stones at the spinal injury unit at the Northern General Hospital on 20.02.23, undergoing surgery on 23.02.23. He failed to come round from the anaesthetic and died from swelling in the brain as set out above. The cause of the thrombosis could not be established.

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. -

During evidence from the family and [redacted], author of the internal investigation, it became clear that although Craig had received care for the shunts implanted as a consequence of his hydrocephalus as a young person, this did not continue as an adult. Also, there was no process for review of patients such as Craig.

[redacted] gave evidence that there remained no transfer protocol or pathway in place as children move into adulthood as at the current date nor an effective review process for adults at the present time. In evidence she stated that it was important that a clear pathway, including for transitions between childhood and adulthood, was in place and a failure to have such clear pathways and protocols such that people who needed care could easily access it could potentially be fatal.

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ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you as the Chief executives of the Sheffield Childrens and teaching Hospital Trusts have the power to take such action.

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YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 21.05.24. 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] (Parents)

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.

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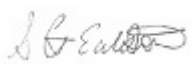
26 March 2024

Signature 

Steve Eccleston H.M Assistant Coroner for