**OFFICE OF THE**
**SENIOR CORONER**
for the County of West Yorkshire
(Eastern District)

**His Majesty's Coroner's Office**
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS
[redacted]

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**THIS REPORT IS BEING SENT TO:**<br>**1. [redacted], Chief Executive, National Institute for Health and Care Excellence** |
| 1 | **CORONER**<br>I am Oliver Robert Longstaff, HM Area Coroner for the Coroner Area of West Yorkshire (East). |
| 2 | **CORONER'S LEGAL POWERS**<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>On 12/10/2021 I commenced an investigation into the death of Antonio Galisi-Swallow who died in the Leeds General Infirmary on 7th October 2021, three weeks short of his 16th birthday. The investigation concluded at the end of the Inquest on 04/12/2025.<br>The medical cause of death was 1a) Propofol-Related Infusion Syndrome ("PRIS"); b) Prolonged Propofol Administration Post Cardiac Surgery; 2) Trisomy 21 with Surgically-Corrected Congenital Cardiac Malformation.<br>In summary, the narrative conclusion to the inquest was that Antonio died from the effects of receiving a continuous propofol infusion of 5634 milligrams plus additional bolus doses over a period of 121 hours, while in post-operative sedation on the Paediatric Intensive Care Unit ("PICU"). |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Antonio had Downs, ADHD and was on the Autistic Spectrum Disorder. He was born with Tetralogy of Fallot, a congenital cardiac malformation that required a series of surgical interventions.<br>He underwent a pulmonary valve implantation procedure on 30th September 2021 to address his severe pulmonary valve regurgitation. Following surgery, Antonio was admitted to the PICU under sedation with significant ventilatory requirements related to a presumed chest infection for which he was given antibiotics, requiring mechanical ventilation for a longer period than |

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| | originally intended. Antonio's sedation was maintained from 30th September by a constant propofol infusion and occasional bolus doses, the overall rate of infusion being gradually reduced, but never stopped.<br>From 4th October, Antonio developed a persistent and increasing fever, though his infection markers were falling. On 5th October he was noted to have a Stage 1 acute kidney injury, although his infection markers were either normal or still falling. His clinical features were consistent with a resolving chest infection, his worsening pyrexia and renal failure being likely due to another pathological process.<br><br>On 6th October, concern was raised for the first time that Antonio's deterioration might be due to PRIS. His propofol was stopped and replaced with fentanyl. Blood tests for creatine kinase, triglycerides and lactate were strongly supportive of the suggested diagnosis. By the evening of that day, Antonio was displaying what an expert witness described as almost all the classically reported features of PRIS.<br><br>Tests and investigations to confirm a diagnosis continued into the early hours of 7th October, although Antonio's parents expressed concerns that their son had been through enough and should be allowed to pass away. He went into cardiac arrest at 0337h and, despite attempts at resuscitation, was pronounced deceased at 0400h. |
| 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>There is no national guidance for the use of propofol for short term sedation in children and young people on PICU's.<br><br>Following Antonio's death, the Leeds Teaching Hospitals Trust has devised and implemented a "Guideline of the use of propofol for short term sedation in children and young people on PICU (by consultant approval only)". The consultant paediatric intensivist who appeared at the inquest as an independent expert witness wholeheartedly endorsed that document, and opined that, had its provisions been in place in October 2021, it is likely that Antonio would not have died when he did. A copy of that document is attached.<br><br>As a coroner making a report of this nature, it is not for me to recommend to any third party that the document developed by the Leeds Teaching Hospitals Trust, or any document like it, should be either more widely disseminated or adopted as official guidance. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you or your organisation have 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 23/01/2026. 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 or their legal representatives: Antonio's parents; Leeds Teaching Hospitals Trust; [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response. |

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| | 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.<br><br>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 | Si<br>[redacted]<br>OLIVER LONGSTAFF<br>Area Coroner<br>West Yorkshire (E)<br><br>Date: 04 December 2025 |