	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. SECRETARY OF STATE FOR HEALTH & SOCIAL CARE** **2. DIRECTOR OF ORGAN AND TISSUE TRANSPLANTATION, NHS BLOOD AND TRANSPLANT SERVICE**
1	**CORONER** I am Adrian Farrow, assistant coroner, for the coroner area of Greater Manchester South
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** An investigation was commenced into the death of Maisie Kate Almond. The investigation concluded at the end of the inquest on 26th February 2026. The conclusion of the inquest was that Maisie died on 2nd October 2024 at Leeds General Infirmary, Leeds. She developed acute liver failure which first manifested itself on 15th September 2024 for which no underlying cause could be found despite exhaustive investigations both at Tameside General Hospital and the specialist Liver Centre in Leeds. She developed consequential swelling to her brain and damage to other internal organs which brought about her death whilst awaiting urgent liver transplant surgery. I concluded that she had died from the effects of a rare form of acute liver failure before a suitable donor liver could be found for priority transplantation.
4	**CIRCUMSTANCES OF THE DEATH** Maisie was 14 years old. She was fit and healthy with no history of any underlying health issues. She became ill on 15th September 2024 and was admitted to Tameside General Hospital on 16th September 2024 and was diagnosed with hepatitis. Investigations were undertaken over the course of the following 10 days, with three separate admissions to hospital with worsening condition. The investigations ruled out any identifiable infections, genetic or other causes the acute failure of her liver. Throughout this process, the hospital worked with the advice of the northern Liver Centre based at Leeds General Hospital. On 26th September 2024, Maisie was transferred to the Liver Centre in Leeds and on 27th September 2024, she was listed for liver transplant. A suitable donor liver did not become available until 1st October 2024, but which time, Maisie had sustained cerebral oedema and other organ damage which made the prospects of her survival so low that the transplant did not take place and Maisie died on 2nd October 2024. The medical cause of her death was: **1a) Cerebral oedema and multi-organ failure;** **1b) Seronegative acute liver failure.**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 the inquest, I heard evidence from a consultant paediatric hepatologist that there

	is a national shortage of donor livers generally and particularly for children in the "super urgent" category. The clinical guidance not to utilise cardiac death donor livers in such cases due to the poor historical outcomes has narrowed the pool of suitable donor livers to those arising from brain deaths. Altruistic living liver donations are generally not available for super urgent cases. The evidence I received was that the number of donor livers has reduced by a third and the effect is that whereas, historically, a donor liver could be expected to be made available within 48 hours, the wait has now extended to up to a week. That delay gives rise to a clear risk that lives will be lost due to the unavailability of suitable donor organs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 **24th April 2026**. 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; Maisie's parents on behalf of the family, Clinical Director and Consultant Paediatric Hepatologist Children's Liver Unit, Leeds Teaching Hospitals NHS Trust, Paediatric Clinical Lead, Tameside General Hospital, who may find it useful or of interest. 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	**Adrian Farrow** **HM Assistant Coroner** [redacted] **27/02/2026**