

GRAEME HUGHES
HIS MAJESTY'S
SENIOR CORONER
SOUTH WALES CENTRAL
CORONER AREA



CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW



ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>The Chief Executive Cardiff & Vale University Health Board</p> <p>The Chief Executive Cwm Taf Morgannwg University Health Board</p> <p>The Chief Executive Powys Teaching Health Board</p> <p>The Chief Executive Hywel Dda University Health Board</p> <p>The Chief Executive Betsi Cadwaladr University Health Board</p> <p>The Chief Executive Aneurin Bevan University Health Board</p> <p>The Chief Executive Swansea Bay University Health Board</p> <p>The Chief Executive Velindre University NHS Trust</p> <p>J [REDACTED] Cabinet Secretary for Health and Social Care</p>
1	CORONER

	<p>I am Rachel Knight H M Coroner, for the coroner area of South Wales Central.</p>
<p>2</p>	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
<p>3</p>	<p>INVESTIGATION and INQUEST</p> <p>On 26th February 2026, I concluded an inquest into the death of SUMMER RAE MANT. I reached a narrative conclusion as follows:</p> <p>Summer Rae Mant was born with MIRAGE syndrome which amongst other things, impacted her ability to fight infections. She developed a severe infection and virus and whilst an inpatient at Prince Charles Hospital Merthyr Tydfil on 17th March 2024, reached the ceiling of ward-based care. During an attempt to switch between high flow nasal oxygen and the CPAP machine on 18th March, there was a rapid desaturation which led to a period of hypoxia and a cardiac arrest. Following this, there was a further arrest during intubation, with another period of hypoxia of up to 8 minutes duration. These events of 17th and 18th March likely led to an irreversible hypoxic brain injury. Summer was transferred to PICU in Bristol and subsequently Cardiff, but never made any meaningful recovery. Aged 4, she developed a sudden multi-organ failure in mid-September 2024, with an uncertain cause. Sadly, her condition worsened, and a decision was made to provide palliative care and she died at Ty Hafan on 21st September 2024.</p> <p>Although there were missed opportunities and sub-optimal care around the time of the acute desaturation on 17th and 18th March 2024, it was impossible to ascertain the precise contribution of the various factors, in the context of Summer's MIRAGE syndrome and compromised immune system. The development of the multi-organ failure which directly led to death was likely multi-factorial in nature.</p> <p>Her cause of death was:</p> <p>1a Unexplained multi-organ failure in a 4 year old child with MIRAGE syndrome, following a prolonged inpatient stay due to an acquired brain injury from March 2024 following a period of hypoxia whilst being treated for parainfluenza virus and a superadded chest infection.</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Inquest focused upon:-</p> <ul style="list-style-type: none"> a. The events of 17th and 18th March; and b. Summer's cause of death
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows.</p> <p>During the resuscitation of Summer at Prince Charles Hospital in theatre following intubation, there was a delay in obtaining adrenaline. The incident occurred at night and it involved a skeleton staff including some junior doctors, fairly new to the hospital.</p> <p>The delay in finding adrenaline, was likely due to the fact that there is no standardised crash trolley, and junior doctors frequently rotate between hospitals and health boards and encounter different set-ups.</p> <p>Paediatric crash trolleys are necessarily different to adult crash trolleys, but there was consensus in evidence that it would be safer if there was a single standardised version of each type across every hospital setting in which junior doctors rotate, to minimise confusion at a time critical moment.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 120 days of the date of this report, namely by 27th June 2026. I, the Coroner, may extend the period.</p>

	<p>In this instance, as this will require thought and collaboration between all the Health Boards in Wales, and potentially input at Welsh Government level, I have extended the usual period, and would be content to receive a single agreed response.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to family who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p>
9	<p>27 February 2026</p> <p>SIGNED:</p> <p></p> <p>Rachel Knight H M Coroner for South Wales Central Coroner Area</p>