ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive HUTH**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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** On 6th January 2026, I commenced an investigation into the death of Garth Pretorius, aged 36 years. The investigation concluded at the end of the inquest on 1st May 2026, the narrative conclusion of the inquest was:- **Garth Pretorius underwent a microdissection testicular sperm extraction procedure on 19th December 2024 due to azoospermia consequent on Klinefelter's syndrome. The procedure was uneventful but just over a week later, he became unwell and presented to the out of hours service at Goole Urgent Treatment Centre. He was found to have red flags for sepsis and was told to attend the Emergency Department at Hull Royal Infirmary. Despite the diagnosis of sepsis being made at `Goole, the Sepsis 6 pathway was not instituted and due to confusion over the arrival of an impending emergency at Hull Royal Infirmary, Garth Pretorius and 15 other patients were effectively told to leave the department. As a result of this, there was a delay of approximately 24 hours in commencing appropriate treatment for sepsis which is a time sensitive condition. This delay more than minimally, negligibly or trivially contributed to Garth's death at Castle Hill Hospital on 3rd January 2025.**
4	**CIRCUMSTANCES OF THE DEATH** Please see attached findings of fact.

5	**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. – Evidence was heard from the Court's independent expert that it is unacceptable for two different triage systems to be employed simultaneously in the Emergency Department of Hull Royal Infirmary. Professor Fletcher gave evidence that the Manchester system is validated and internationally accepted, but at material times, another system was used and continues to be used. Some practitioners use the Manchester system whilst others use a different system. Evidence was heard that the use of the Manchester system requires training and there do not appear to be sufficient resources still available for it to be adopted universally at Hull Royal Infirmary.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action. This may include, for example, allocating the necessary resources to fast track the universal adoption of the Manchester Triage System in the Trust.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **3rd July 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 [redacted]. I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. 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	PV Marks **H.M. Senior Coroner** [redacted] **8th May 2026**