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. The Secretary of State for Education** **2. The Secretary of State for Health** **3. The Chief Executive of North West Ambulance Service Trust**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of 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** On the 26th October 2012 I commenced an investigation into the death of Millie Elizabeth Josephine Thompson. The investigation concluded at the end of the inquest on 5th December 2013. The conclusion of the inquest was that Millie died from 1a Choking and a conclusion of Misadventure was recorded by the jury..
4	**CIRCUMSTANCES OF THE DEATH** On the morning of the 23rd October 2012 Millie, then aged 9 months, was taken to Ramillies Nursery in Cheadle Hulme, Stockport, Greater-Manchester. This establishment which is registered with OFSTED caters for children from age 6months to 16 years. Whilst she was being fed Shepherd's Pie for lunch that day, she started to choke, she inhaled some of the food which eventually lodged in her left main bronchus, this led to her sustaining a tension pneumothorax leading to the cardiac arrest which was the underlying cause of death. When the call was made to the Ambulance service, the call taker wrongly assessed and allocated it thus meaning that a Rapid Response vehicle was not despatched. The crew of the first ambulance found that the oxygen mask that they had on their vehicle did not properly fit a very young child and they had to call for the assistance of a second crew.
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. – During the course of the evidence it became apparent that there were only a few members of staff at the Nursery who had undergone Paediatric First Aid training, and

	that there is a need for specialist training when confronted with certain medical conditions affecting very young children. Other members of staff had general First Aid training but this appears to have been less useful in the circumstances. It also transpired that the First Aid certification of some of the staff had lapsed by the passage of time, so that although they had undergone the training it now needed updating. The EMD (call-taker) for the Ambulance Trust is a non-medically trained person who simply takes the details and reads from the appropriate "card" as to what questions should be asked and what advice should be given as well as determining how the case is to be triaged and allocated. It appears that because of a misinterpretation by that person as to the question of "ineffective/effective breathing", the case was wrongly allocated. I took the view that ALL nursery staff should be subject to mandatory paediatric First Aid training; that there should be better selection and training of Call-Taking staff for the ambulance service; that ALL emergency ambulances (including rapid response vehicles) should be equipped with suitable paediatric life-saving kit.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, jointly and/or severally, 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 3rd February 2014. 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, namely [redacted] (parents of Millie), Ramillies Hall School, Chief Executive of Stockport NHS Foundation trust and to the LOCAL SAFEGUARDING BOARD. 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	**6th December 2013** **John S. Pollard** **H.M. Senior Coroner**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)