REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chair of SENAT, Birmingham Women's Hospital, South-West Midlands Newborn Network**
1	**CORONER** I am Miss Sarah Ormond-Walshe, Assistant Coroner, for the Birmingham and Solihull Districts
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** I commenced an investigation into the deaths of: Caitlynn Bethany Jane Bennet Mohammed Gulam Mohinudeen Alfie-Scott Harris The investigations concluded at the end of the final inquest on 5th September 2013. The conclusion of the inquests were as per the attached Inquisitions/Record of Inquest.
4	**CIRCUMSTANCES OF THE DEATH**
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. –

(1) NNU staff are not aware that cardiac tamponade may not be such a rare complication of TPN feeding as is thought.
(2) NNUs may not be sharing best practice to limit this complication.

This is the second Report that I am sending out in relation to an issue about babies dying of cardiac tamponade as a complication of central lines being put in for parental nutrition.

I have now heard the evidence in relation to the third death and I am sufficiently concerned to write a further report. For everybody's information, the first report was sent to Sir David Nicholson, Chief Executive of the National Health Service and it must have been forwarded onto The Royal College of Obstetricians and Gynaecologists by The National Health Services. The response from the Royal College stated that this was not a matter for them but it is a matter for the Royal College of Paediatrics and Child Health. In the meantime, matters have overtaken that and I have heard the Inquest in relation to the third death.

I had asked for a report from a Senior Consultant Neonatologist, [redacted] who has written me a report indicating essentially, that she has no concern about links between the three cases and that it is a known complication. I am aware that this doctor has now retired.

In the third case that I heard of Alfie-Scott Harris, I have found that there were failures in relation to the placement of the end of the long line that he had in, although I did not find these to be gross, and, despite [redacted] report, at the very least, it seems to me, that it should not be assumed that this is a rare complication.

I have heard that City Hospital have brought in new measures to reduce the incidence of any failures in the future, (for instance having a high resolution x-ray scanning equipment on the Neonatal Unit as well as in Radiology, so that the clinicians can look at the x-rays. I refer to my summing up which is attached to this document). I am concerned that each Unit may not be sharing best practice about what is being done to minimise any risk.

	I am very conscious that this is a complicated medical issue which I have heard in some detail but you, as a clinician, will no doubt be aware of significant medical research that assists with clinical decision making about care of these lines. However, from my point of view, the first Inquest I heard in relation to this type of death was one where I was told that this was a complication which was incredibly rare. I am also told in the last Inquest of Alfie-Scott Harris, that there have lessons that have been learned and that changes have been made. I am not assured that any changes that have been made in one unit, had not been at least considered in another unit in relation to the same facts. Although not exhaustive, I have compiled a short table with the dates, times, hospitals, types of line and it is very clear to me that these are different units, different lines put in by different people at different times. However, for reasons outlined above, I would be grateful if this matter could receive your attention and if there is anything to be learned from it or disseminated either throughout Birmingham or even more nationally in any scientific journal, I would obviously wholeheartedly support this. The guidance we have is that we are slow to make and specific "recommendations" as such in these reports - and I consider this particularly relevant in relation to complex medical procedures/issues. Therefore I simply say I bring these set of circumstances to your attention and do not suggest a particular path/change etc.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or the Women's Hospital or the Newborn Network 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 14th November 2013. 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 **Chairman, Royal College of Paediatrics and Child Health**

	Chairman, British Association of Perinatal Medicine [redacted] **Birmingham Heartlands Hospital** 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	**19th September 2013**