IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Archie Hames
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Surrey Community Health Secretary of State for Health
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 30/1/12 I opened the inquest into the death of Archie Hames, who at the date his death was 3 years old. The inquest was resumed and concluded on 4/6/14. I found that the cause of death to be: 1a – Cerebral hypoxia 1b – Airway obstruction (dislodged tracheal tube) 1c – CHARGE syndrome I concluded with a narrative conclusion as follows: On 15th January 2012 Archie Hames who was born with CHARGE syndrome and reliant on assisted respiration through a tracheostomy, was found unresponsive at his home address. Upon the arrival of paramedics he was resuscitated and taken to hospital, where he was found to have suffered irreversible brain dmage and he succumbed and died of cerebral hypoxia on 19th January 2012. It is more likely than not that his tracheostomy device became dislodged when the attaching

	Velcro strap caused wear and failure to the eyelet of the tracheostomy tube, causing it to fracture and work loose leading to cerebral oxygen starvation and death.
4	**CIRCUMSTANCES OF THE DEATH** 3 year old Archie Hames lived with his parents at their home address and he suffered from Charge Syndrome necessitating a tracheostomy in situ. He was at his home address on the morning of 15th January 2012 when his parents discovered that his tracheostomy tube was displaced and he was unresponsive. Upon the attendance of the paramedics he was resuscitated and taken to hospital where he was found to have suffered irreversible brain damage and he very sadly succumbed and died of cerebral hypoxia on 19th January 2012. It was subsequently found that the attaching Velcro strap to the tracheostomy tube had caused wear to its eyelet causing it to become detached causing airway obstruction and death.
5	**CORONER'S CONCERNS** During the inquest the following concerns arose:- • Independent expert testing of the tracheostomy tube (model AMFNF-49) manufactured by Arcadia Medical and its attaching Velcro strap (model Trachi-Hold mini, TR ACC) manufactured by Kapitex Healthcare, confirmed that their combined use compromised the integrity of the silicone eyelet to the tracheostomy tube and was more likely than not to have caused the detachment of Archie's tube • The further implications of such continued use • The implications of using Velcro strap attachments with other like tracheostomy tubes. I would ask that you consider give further consideration to the appropriateness of using Velcro strap attachments with tracheostomy tubes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Surrey Community Health and the Secretary of State for Health has the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • • Kapitex Healthcare • - MHRA • Children's Community Nursing Team – Kingston Hospital • ge – Medical Device Team – Welsh Government • – Medical Device Team – Welsh Government • – Medical Device Team – Northern Ireland • – Patient Safety lead for medical devices for Scotland • - NHS Commissioning Board Authority • – Princess of Wales Hospital • Chief Coroner
9	**Signed: Martin Fleming** **DATED this 5-June-2014**