	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re Christ Morrison 02688-14, died 17.10.14 (HD)** THIS REPORT IS BEING SENT TO: 1. [redacted] Medical Director of Epsom and St Helier, University Hospitals NHS Trust, Queen Mary's Hospital for Children, Wrythe Lane, Carshalton, Surrey SM5 1AA
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner 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** An investigation was opened into this death. Following an autopsy, which found that death was due to hypoxic ischaemic encephalopathy due to failure to resite a tracheostomy tube, an inquest was opened. A pre-inquest review was held and submissions obtained from a large number of potential interested persons, before the scope could be refined. It was adjourned part-heard for further evidence on 25th August 2015.
4	**CIRCUMSTANCES OF THE DEATH** At inquest on 19th February 2016, a narrative conclusion was recorded: *Baby Christ Morrison was born at 24 weeks gestation by fast spontaneous delivery on 20th May 2005. He was initially thought to be stillborn, and was therefore not attended by staff, but was found later to have a pulse and chest movements and was resuscitated and taken to ITU. He was disabled by a degree of brain injury. His first capillary gas and his response to resuscitation make it unlikely that the period of non attendance contributed to his brain injury. Without placental pathology it is not possible to know whether his mother's bleeding was an abruptio placenta, but it is possible that this contributed to his brain injury. The principal cause was extreme prematurity, which caused some chronic lung disease and the need for a tracheostomy. He developed subglottic stenosis, some months later, which was not congenital, but caused by prolonged tracheostomy intubation. He had some tracheal reconstruction surgery. The tube was changed uneventfully on many occasions, but at about 5pm on 10th September 2014, the tube was removed by a nurse, accompanied by his guardian, and he became agitated. Attempts to replace the tube failed and emergency services were called. Despite basic life support from the nurse and advanced life support from the ambulance crews, and transfer to a specialist centre, he did not regain consciousness and died at 07.00 hours on 17.10.2014 at St Thomas Hospital.*
5	**CORONER'S CONCERNS**

	The MATTER OF CONCERN is as follows. – It was not clear what level of training was necessary for the staff changing tracheostomy tubes of children at home. The mother was very concerned that this should be performed by a nurse without medical presence. It was also submitted at inquest that in the event of failure to replace a tube, the health care professional should be skilled and equipped to perform a new emergency tracheostomy. This was not the position in this case. Whilst processes for changing tubes has changed since this inquest, with two staff as a minimum now being required to be present, the court was informed that the Epsom and St Helier Paediatric Tracheostomy Policy complied with processes complied with other Trusts. But it makes clear that failure to reintubate requires emergency transfer to A&E rather than emergency tracheostomy and does not require a medical presence.
6	ACTION SHOULD BE TAKEN It is clear that there is some risk of death from routine domiciliary tracheostomy changes, but less clear whether ensuring a higher level of skill or different professional will reduce that risk. Nor is it clear whether other associated benefits of not having to attend hospital outweigh the presumed reduction in risk to lives of having the tube changed where emergency medical resuscitation was available. Expert evidence on these particular matters was not heard. The Trusts is notified of the concerns about future deaths and are asked to consider these. In support of such an exercise, ~~the death~~ this report and Epsom & St Helier Paediatric Tracheostomy Policy is sent to the Royal College of Paediatrics and Intensive Care Society.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 27th, April 2016. 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. If you require any further information about the case, please contact the case officer, [redacted] If you require further information about the process of responding to this report my clerk [redacted] to whom your response should be sent.

8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] (mother), [redacted] (special guardian), [redacted] Trust Solicitor for Kings College Hospital, [redacted] Head of Paediatric Nursing at Epsom & St Helier University Hospital. I am also sending a copy to the [redacted] President of the Royal College of Paediatrics, [redacted] Interim Chief Executive of The Intensive Care Society and the Rt. Hon Jeremy Hunt Secretary of State for Health at the Department of Health. 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	[DATE] [SIGNED BY CORONER] Written: 02.03.2016 Sent: