	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust** **Mr Peter Homa, Chief Executive, Nottingham University Hospitals NHS Trust**
1	**CORONER** I am Heidi Connor Assistant Coroner for **Nottinghamshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30/08/2016 I commenced an investigation into the death of Rohid SHERGILL. The investigation concluded at the end of the inquest 10th October 2016. The conclusion of the inquest was Accident. I found that a naso-gastric tube ('NGT') was inserted into Rohid's lung on 10.3.16 and the tube was used to feed him before this was recognised, resulting in his death.
4	**CIRCUMSTANCES OF THE DEATH** Rohid Shergill was born on 31 May 2002. He had been diagnosed with Duchenne's muscular dystrophy and by March 2016 was in the terminal stages of his illness. He was looked after by loving parents and grandparents at home. He had been fed via an NGT since July 2015. The tube was changed by community paediatric nurses employed by Nottinghamshire Healthcare NHS Foundation Trust. It was accepted by all that a pH test of aspirate from the NGT should always be carried before the tube was used – either for feeding or to give medication. This is clearly set out in a National Patient Safety Alert issued in 2011. Concerns were expressed about whether pH testing was being carried out at home before feeds, and this was explained again to parents in August and October 2015. Rohid's tube was changed by a community nurse on 10 March 2016. She was not able to get any aspirate from the NGT to test , after offering Rohid a drink of water. She did not follow existing trust guidelines to use other 'manoeuvres' to try to obtain some aspirate (such as moving the child's position or moving the tube further in or out). She left, reminding the parents to carry out this test. His next feed was due a couple of hours after this. Rohid was fed by his parents at around midday. His mother gave evidence that she did carry out a pH test before the feed, and that the result was a pH of 5. We heard that any result below 5.5 meant it was safe to feed Rohid. She also said that every pH test she had previously done resulted in a pH of 5.5. She said that she did not know that the purpose of the test was to make sure the NGT did not go into his airway. Rohid's mother said that she used the same syringe (to obtain aspirate for testing) that she had used earlier that morning, when the pH was 5.5. She said that she washed this out before using it again. The possibility of contamination of the syringe was raised. We were told that the syringes are designed to be used more than once, provided they are washed and dried between uses.

	Rohid deteriorated soon after having the feed. A physiotherapist attended, and administered liquid paracetamol, again without checking the pH or asking family if this had been done. She did not know at that time that the NGT had been changed that day or when he had last been fed. I found there was a clear underestimation on the part of this witness as to the significance of putting even just 5ml of liquid paracetamol into the lungs of a very sick child. The physiotherapist is employed by a different trust (Nottingham University Hospitals NHS Trust) and could not access the records made by community nurses. There was no shared 'care folder' at the family home. The physiotherapist arranged for Rohid to go to hospital. There it was discovered that the NGT was in his lung. Despite the hospital's best efforts, Rohid died there on 14 March 2016. His cause of death following a post mortem examination was aspiration pneumonitis – his death had clearly been caused by the liquid which had gone into his lungs via the NGT. I found it likely that the NGT had been in Rohid's airway from the time it was placed, on 10 March 2016. A pH of 5 is not consistent with the tube being in his airways. It was not clear if contamination of the syringe played any part in this result. I found it likely that no adequate / accurate pH test was done before Rohid was fed. I also found that insufficient efforts were made by the community nurse on 10 March 2016 to check the position of the NGT she had inserted, or to seek advice if she could not obtain aspirate to test. Some work and negotiation between the trusts has begun, to address the issues arising out of this tragic death. It is clear that this process is far from complete however.
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. Ensuring that parents of children fed in this way are completely happy with what they have to do, and understand the significance of it. There was clear confusion about whether this was the responsibility of the school nurse or the community nurses (then working separately). Urgent consideration should be given to an agreed protocol to ensure parental competence wherever an NGT is first used – in the community or in hospital. 2. Information-sharing between the two trusts – by way of shared IT and / or the use of shared care folders kept in the family home – with clear training to staff on what information should be recorded there. 3. Clear guidance on a named keyworker / lead nurse who is responsible for coordinating the care of children cared for in the community. 4. Training to physiotherapy teams regarding the importance of pH testing (or at least confirming this has been done) before administration of medication. This should be considered for other disciplines who routinely visit sick children at home and prescribe medication – such as occupational therapists / speech and language therapists. 5. There should be a review of the policy of syringes being used multiple times for pH testing aspirate from NGTs – and whether this results in a risk of contamination and therefore falsely reassuring results.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 8 December 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : 1. Family of Rohid Shergill 2. Local child safeguarding board 3. Ms S Eagling, head of legal services, Nottinghamshire Healthcare NHS Foundation Trust 4. [redacted] head of legal services, Nottingham University Hospitals NHS Trust 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	12/10/2016 Signature_____ Heidi Connor Assistant Coroner Nottinghamshire