REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health, Chief Executive of Manchester University NHS Foundation Trust (Royal Manchester Children's Hospital, St Mary's Hospital), Chief Investigating Officer of Health and Safety Investigation Branch
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester
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 On10th day of July 2017 I commenced an investigation into the death of Joseph James GRANTHAM. The inquest concluded on the 31st August 2018 and the conclusion was one of **Natural Causes.** The medical cause of death **was 1a) Sudden and unexpected death of unknown cause on a background of neural tube defect (cervical meningocele, hydrocephalus, Arnold Chiari type II malformation) and laryngomalacia.**
4	CIRCUMSTANCES OF THE DEATH Joseph James Grantham was born on 9th March 2017 with a neural tube defect. In addition he developed laryngomalacia. He developed stridor. It was decided by specialists at Royal Manchester Children's Hospital that he should be operated on for his neural defect and laryngomalacia. On 9th July 2017 whilst at church, it was noted he had become unresponsive. He was taken to Tameside General Hospital where efforts to resuscitate him were unsuccessful. After his death, a post mortem found no cause of death; however his death was attributable to natural causes.

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. After his birth Joseph was transferred to the neonatal unit at St Mary's due to the complexities of his health. Following his discharge, it took 6 weeks for the trust to send the discharge paperwork to the GP and the District General Hospital (DGH) to whom they were transferring his paediatric care. As a result, there was no clear understanding amongst health professionals as to the paediatrician with responsibility for his care. Letters were therefore copied into a mixture of paediatricians. The discharge letter to the DGH was addressed to a consultant who was in fact a registrar at the trust. 2. Joseph was under the care of the paediatric neurosurgical team at the Royal Manchester Children's Hospital (RMCH). Letters from the neurosurgical team following out-patient appointments took 4 weeks to be sent out. As a result one letter to a paediatric anaesthetist asking for an examination was not typed until after the operation was due to take place. When his mother took him for review, she had to escalate the need for him to be seen by the paediatric anaesthetist who then deemed him not fit at that time for surgery. 3. At ENT appointments and neurosurgery appointments at the RMCH, Joseph was seen without the paper notes because they had not been made available to the clinicians seeing Joseph. 4. Joseph had been diagnosed by the neurosurgeons at RMCH with neural tube defect (cervical meningocele, hydrocephalus, Arnold Chiari type II malformation. A recognised complication is hydrocephalus. Identification of the onset of hydrocephalus is through measurement of head circumference. The inquest heard that when Joseph was discharged from St Mary's the neurosurgical team did not send written instructions to community health professionals explaining what was required and why it was required. The midwives measuring his head were unsure why they were measuring it or what to do with the information. 5. Joseph's health needs relating to neural tube defect (cervical meningocele, hydrocephalus, Arnold Chiari type II malformation and laryngomalacia were dealt with by the RMCH. His paediatric care was transferred without discussion by St Mary's back to the DGH. The inquest was told that there is no set protocol/ procedure between tertiary centres and DGH's for this situation, which can lead to differing practices. 6. Joseph's red book had been completed sporadically. The inquest heard from a number of witnesses who indicated that practice re

	completion of the red book amongst health professionals nationally was mixed and that there was no clear guidance for or expectation amongst health professionals that they would be widely used other than for post birth weight recording and immunisations. As a result there was no composite record of health concerns for a young child such as Joseph. Differing IT systems meant that health professionals in different trusts were reliant on verbal information passed to parents placing a significant burden on parents and a risk that key information was not available.
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 13th December 2018. 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 1) [redacted] Joseph's Parents and 2) Tameside General Hospital, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **18.10.2018**