REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. North West Ambulance Service (NWAS) 2. Pennine Care NHS Foundation Trust
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION AND INQUEST** On 21st May 2019, an investigation was commenced into the death of **Muhammed Saif Abdul Haleem** (dob: 12 November 2005). The investigation concluded at the end of the inquest on 24th September 2019. The inquest determined that the medical cause of death was 1a) Unascertained. The conclusion was Natural Causes.
4	**CIRCUMSTANCES OF DEATH** Muhammed was 13 years old at the time of his death and had been born with a severe, life-limiting neurological condition. He had congenital muscular dystrophy secondary to a gene mutation and severe learning disability. He was non-verbal and could not mobilise by himself. He had a permanent tracheostomy fitted in November 2011 and was fed via a Percutaneous Endoscopic Gastrostomy. In October 2011, when Muhammed was 6 years old, he had suffered an acute episode of severe pneumonia and received intensive care at Royal Manchester Children's Hospital. He had been discharged from hospital on 14 November 2011 and those responsible for his care were of the opinion that his death was imminent. A DNA-CPR document dated 11 November 2011 was forwarded to his GP and NWAS. Following this acute episode, Muhammed's condition stabilised and after 2012, he had no further in-patient admissions. He was cared for at home and attended Special Schools. He was under the care of the Community Paediatric Team and in the last six months of his life had been seen by specialists in nephrology, orthopaedics and respiratory medicine at the Children's Hospital. His condition was regarded as stable. Those involved in his care were unaware of the existence of the 2011 DNA-CPR document and I heard evidence from a Consultant Paediatrician that a DNA-CPR at this time was 'totally inappropriate.' Muhammed had attended school the week before his death and I heard evidence from a School Nurse who had seen him on Tuesday 4th December that he was 'really well'. On Saturday 8th December, Muhammed had woken in the early hours which was not unusual for him. He went to sleep at about 10am and was checked by his mother at 11am. When his mother tried to rouse him for his feed shortly after 12 noon, she discovered that he was unresponsive. NWAS was called at 12:18 hours and when the first paramedic arrived at 12:24 hours, Muhammed was in asystole and there was no respiratory effort. The paramedic attempted resuscitation and was joined by further

	crews who continued with resuscitation. Despite those efforts, Muhammed remained in asystole throughout and resuscitation was terminated at 12:40 hours. During the resuscitation, the paramedics had sought advice from the NWAS Clinical Support Hub who advised that a pre-written warning was in place that resuscitation would not be in Muhammed's best interests. The pre-written warning on the NWAS system was undated but had been taken from the DNA-CPR document dated 11 November 2011. I found on the evidence that Muhammed's condition at the time the paramedics attended on him and the lack of response to resuscitation efforts meant that he would not have responded to further resuscitative efforts, had they been continued. Muhammed was transferred to the Royal Oldham Hospital where his death was certified at 14:40 hours on 8th December 2018.
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:- That information held on the NWAS system for the purpose of providing immediate guidance to paramedics was 7 years out-of-date and was not known to or supported by the clinicians involved in this child's care at the time of his death. Whilst I accept the evidence that paramedics will make a clinical decision based on the patient's presentation at the time, the fact that they sought advice around the existence of a DNA-CPR indicates that it is a relevant factor in their decision-making The evidence was that the number of children living in the community with DNA-CPRs in place is small and there should be communication between the community paediatric teams and emergency services of any DNA-CPRs or Advance Care Plans that are in existence and are current.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **20 November 2019**. 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:- [redacted](Muhammed's mother) [redacted] Greenbank Medical Practice Forget Me Not Hospice I have also sent a copy of this report to Royal Manchester Childrens Hospital who may find it 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 from. He may send a copy of this report to any person who he believes may find it usefulor 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: 24 September 2019 Signed: