Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] **- Chief Executive Officer, NHS England** • [redacted] **- President, ENT UK** • [redacted] **- Chief Executive Officer, East Sussex Healthcare NHS Trust** • [redacted] **Chief Executive Officer, Brighton and Sussex University Hospitals NHS Trust** • [redacted] **- Group Chief Executive Officer, Bourne Leisure Ltd (Butlin's)**
1	**CORONER** I am Karen Harrold, Assistant Coroner, for the coroner area of West Sussex.
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** On 02 July 2018 I commenced an investigation into the death of James Joseph MANNING aged 2. The investigation concluded at the end of the inquest on 12 March 2021. The overall conclusion of the inquest was a short form conclusion of Accident and the mechanism of death was explained in Box 3 of the Record of inquest as follows: On 6 June 2018, James Joseph Manning a two year old child was with his mother and Nan, having breakfast in the Ocean Drive restaurant in Butlins, Bognor Regis. Whilst his mother was cutting up his food, unbeknown to her, James grabbed a large piece of sausage and gasped it down. He started to choke as the sausage was stuck in his vocal chords below his enlarged tonsils causing a total obstruction. Despite bystander CPR and first aid the sausage could not be dislodged. A 999 call was made and on the arrival of paramedics they observed James was deeply cyanosed and asystole. It took the paramedics 7 to 8 minutes to remove the sausage by using a laryngoscope and Magill forceps during which time James remained asystole and suffered a 7 to 8 minute cardiac arrest causing hypoxic ischaemic brain injury. James was stabilised and taken to hospital where despite extensive treatment in PICU at Southampton General Hospital life supporting therapy was withdrawn and he died at 10:53 on 20 June 2018.
4	**CIRCUMSTANCES OF THE DEATH** James died from hypoxic ischaemic brain injury on 20 June 2018 at Southampton Children's Hospital due to a cardiac arrest following choking on a piece of sausage on 6 June 2018 as described above. James was well-known to his GP and local hospital (Conquest Hospital) as there had been multiple episodes of choking including 21 May 2017 when James choked on a piece of chicken, went blue and floppy for two minutes. The piece of chicken was dislodged with back slaps. During the inquest, this episode was described by experts as life-threatening. James was admitted to Conquest Hospital for an overnight stay and at that time his tonsils were described as grade 3-4. He was referred back to his GP and there was no follow-up by

	the hospital. James was seen by his GP practice for various issues in June and August including suspected tonsillitis when he was prescribed antibiotics. On 30 August 2017 James was seen by his GP after a further episode of choking on a piece of sausage and his tonsils were described as large. James was referred by his GP to the ENT specialist at the Conquest Hospital. This was a routine referral and James was not seen until 5 December 2017. Significant tonsillar hypertrophy (grade 3-4) was identified plus a concern was raised about the possibility of sleep apnoea. James was referred for a sleep study at Conquest Hospital. An overnight pulse oximetry sleep study was conducted on 2 January 2018 which demonstrated severe obstructive sleep apnoea. James was not seen again in the outpatient's department until 21 March 2018. He was referred to Brighton hospital for consideration of adenotonsillectomy on a routine basis. Whilst waiting for an appointment in Brighton, James went on holiday to Butlins Bognor Regis with his mother and grandmother on 3 June 2018. The final choking event occurred on 6 June. Further details of James's extensive previous medical history and my findings after hearing 10 days of evidence is included in the written summary and judgment attached.
5	**CORONER'S CONCERNS** During the investigation, my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: **Healthcare** a) I heard expert evidence that GPs and general hospital doctors would benefit from national guidance to ensure that greater consistency is achieved when referring children for tonsillectomy and similar treatment. In addition, both GP and hospital doctors gave evidence that raised a concern regarding: i. whether additional guidance may be appropriate to help doctors decide which cases need an urgent referral to hospital or tertiary care; and ii. a system of red flags – for example including choking in the ENT UK Commissioning Guide for Tonsillectomy (2016). Experts and witnesses confirmed that choking is not mentioned in the current Guide. b) I also heard evidence from experts that when a child chokes as James did in May 2017, the risk of a life-threatening event is high. I was concerned to hear that A&E paediatricians could either refer directly to ENT specialists or arrange a follow-up visit to assess the likelihood of a repeat choking episode but in this case the child's mother was referred back to the GP. c) I heard evidence that at some points in James's medical care there were delays in being reassessed especially following the sleep study. The delay in being reassessed and referred to tertiary care was contributed to by medical staff being on leave. Doctors will inevitably have leave yet I am still concerned that systems in place at that time were not sufficiently robust to ensure suitable cover was in place to progress urgent cases. d) I also heard evidence to suggest that locally devised priorities agreed in specialist or

	tertiary centres (in this case the Royal Sussex County Hospital, Brighton) had not been communicated to local hospitals and shared so that doctors making a referral can consider the best place to refer a case taking into consideration relative waiting times. e) One expert medical witness gave evidence that it may help other parents in a similar position to the parents in this case to be given a leaflet by Emergency and ENT departments setting out advice on choking hazards including food and/or how best to manage a choking episode including what information to give during a 999 call. **f)** At several points during the inquest, questions were asked of medical witnesses about how best practice is shared between local NHS Trusts and GP surgeries. I am concerned that systems to review how information is shared locally may need to be reconsidered. **<u>Bourne Leisure Ltd (including Butlins)</u>** a) From speaking to a number of witnesses in this case, I was deeply concerned that there was no national system for managing Health & Safety issues across company sites. Staff agreed it would help to share information and learning on a reciprocal basis across all sites. b) After hearing extensive evidence, I was deeply concerned about whether there was a sufficiently robust incident investigation and reporting system in place so that lessons could be learned then shared with staff. c) I am concerned that the Health & Safety Executive's strong recommendation in the First Aid Regulations to consider the first aid of visitors and what will be offered in terms of provision across each site was not sufficiently reflected in company practices. d) I was concerned to hear evidence that many months after this tragic incident during Tots Week, installation of an external phone line and sufficient AEDs in key areas such as restaurants and swimming pool areas had not been completed. e) Witnesses confirmed that there was no written standard operating procedure setting out how staff can get first aid help quickly as well as when and how to make a 999-emergency call especially if a trained first aider is not immediately available.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 11th August 2022 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:- a) [redacted] b) c) d)

	e) Martin's Oak surgery f) East Sussex Healthcare NHS Trust g) South East Coast Ambulance Service NHS Foundation Trust (SECAMB) h) Butlins represented by Chris Green, Keoghs Solicitors i) Brighton and Sussex University Hospitals NHS Trust I have also sent it to: - a) [redacted], Consultant Paediatric Intensivist, Southampton Children's Hospital b) [redacted], Consultant Paediatric Neurologist, Southampton General Hospital c) [redacted], Consultant Paediatric Intensivist, Royal Manchester Children's Hospital d) [redacted], Chief Executive Officer, Health and Safety Executive e) [redacted], Chief Executive Officer, Arun District Council f) [redacted], Child Death Overview Panel Manager, Sussex CCG who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 16/06/2022** Karen Harrold **Karen HARROLD** **Assistant Coroner for** **West Sussex Coroners Service**