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:** **1 NHS England** **2 Chief Coroner**
1	**CORONER** I am Helen RIMMER, Assistant Coroner for the coroner area of Liverpool and Wirral
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 11 October 2023 I commenced an investigation into the death of Eleanor Hazel ALDRED-OWEN aged 1. The investigation concluded at the end of the inquest on 18 December 2024. The conclusion of the inquest was that: The conclusion of the inquest was that cause of death: 1a. Severe hypoxia ischaemic encephalopathy (with coning) 1b. Cardio respiratory arrest 1c. Right tension pneumothorax Conclusion: Misadventure contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Eleanor was admitted to Alder Hey Children's Hospital on 29th September 2023 for elective craniofacial surgery. There was no associated problems or genetic abnormalities, and Eleanor was otherwise well. The procedure for bicoronal synostosis was uneventful except that Eleanor's tracheal tube dislodged towards the end of the procedure and she required reintubating. Eleanor returned to the ward following her surgery and was seemingly stable apart from being tachycardic. Over a period of several hours, she deteriorated with increased breathing and respiratory distress. At 22:35 hours Eleanor sustained a cardiac arrest and required full resuscitation over the course of 20 minutes until return of spontaneous circulation was achieved. A chest x ray that had been ordered at 22:03 hours and was performed at 22:18 hours was grossly abnormal but this was not raised or concerns escalated with any of the medical or nursing staff on the ward. The x ray was not reviewed until 22:40 hours and revealed a right sided tension pneumothorax, which was decompressed and a drain inserted. There was a period of approximately 30 minutes between the x ray being taken at 22:18 hours and bilateral needle decompression being performed at 22:48 hours, effective resuscitation was unlikely to have occurred until the bilateral needle decompression was performed on Eleanor, this delay in the decompression being performed more likely than not contributed to the subsequent ischaemia suffered by Eleanor. Eleanor was transferred to the paediatric intensive care unit and over the course of the next two days became gradually unstable, a CT

	scan of her head was obtained which showed catastrophic hypoxic ischaemic change with evidence of coning. Life sustaining measures were then withdrawn and Eleanor sadly died on 2nd October 2023.
5	**CORONER'S CONCERNS** During the course of 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: 1) Evidence was given at the inquest that the standard operating procedure for radiographers did not include provision for radiographers to escalate care and put out an urgent arrest call where there were clear signs of imminent danger to life. It was not known whether this was also the case in other Trusts on a national level.
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 February 12, 2025. 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 Eleanor's family I have also sent it to Local Children's Safeguarding Board Alder Hey NHS Foundation Trust Chief Coroner 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: 18/12/2024**  **Helen RIMMER** **Assistant Coroner for** **Liverpool and Wirral**