Summary: Regulation 28 Report to Prevent Future death for **James Manning (died 20.9.22)**

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This is a brief summary of the regulation 28 coroners report into the death of James Manning from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

2 year old boy with tonsillar hypertrophy.
Prior recurrent episodes of choking & severe OSA awaiting further management.

Events surrounding death

- Choked on a piece of sausage in a restaurant
- Unsuccessful bystander CPR
- Obstruction removed by paramedics with 7–8-minute cardiac arrest
- Life supporting therapy withdrawn 14 days later due to hypoxic ischemic brain injury

Coroner's Recommendations

- Consider including choking as a red flag in the current ENT UK commissioning guide for tonsillectomy 2016
- Review of local referral pathways to ENT
- Review of the delays in reviewing the reports of medical assessments like sleep studies
- Develop patient leaflets on choking hazards and choking management
- Improving sharing best practice between NHS trusts and GP surgeries

Key Themes

- Lack of clarity on referral and follow-up criteria
- Need for provision/improved dissemination of patient information
- Delays in receiving results of tests
- Issues in information sharing between primary and hospital-based care

Local Improvement suggestions from this report:

- Review & define with ENT, GP & A&E staff what follow-up is needed after choking &/or review robustness of the local referral pathway to ENT
- Improve A&E to GP alerts/updates
- Improve local choking advice patient leaflets.
- Research needed as to whether tonsil hypertrophy &/or OSA is disproportionately seen in children who choke? Are they red flags for poorer outcomes from choking?

For full information visit:
https://www.judiciary.uk/prevention-of-future-death-reports/james-manning-prevention-of-future-deaths-report/
or follow the QR code