In the South London Coroners Court
Inquest touching the death of Samuel Boon

Regulation 28 Report to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: The Rt Hon Michael Gove MP, Secretary of State for Education
1	**CORONER** I am Selena Lynch, Assistant Coroner for the coroner area of South London
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 25 July 2012 an inquest was opened into the death of Samuel Boon. The investigation concluded at the end of the inquest on 13 January 2013. The conclusion of the inquest was misadventure.

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4	**CIRCUMSTANCES OF THE DEATH** On 17th July 2012 Samuel Boon (aged 17) collapsed while trekking in temperatures of about 39ºC on a school trip to the foothills of the High Atlas mountains in Morocco. The trip was arranged through a school expedition company. Leaders rendered first aid, attempted to cool him and asked the local guide to get an ambulance. Over an hour later, a minibus arrived. An ambulance was either not available or requested, and would in any event have had no medical equipment or personnel on board. Cardio pulmonary resuscitation (CPR) was performed by the leaders but this had to stop when Samuel was placed in the minibus because of lack of space and he died some time during the 25 minute journey to a local medical centre. The cause of Samuel's death was either exertional heatstroke and/or hyponatremia caused by excessive intake and/or retention of water. Samuel may have taken desmopressin in the recent past which can cause or contribute to hyponatremia, but it is not possible to determine whether he did so, and if so, whether it did in fact contribute to the cause of his death. The cause of Samuel's death was contributed to by his obesity and lack of fitness and acclimatisation. These risk factors and his tiredness and obvious difficulty in keeping up with the trek were not fully recognised by the leaders, who were inexperienced and lacking in local knowledge. Samuel and his parents were given inadequate and misleading information about the level of fitness required or the risks involved in the trip and how they would be managed. Samuel was not adequately assessed as to his physical ability to participate. Formal risk assessments were inadequate and inaccurate with regard to the risk of heat illness and/or hyponatremia, and the risk of medical emergency generally. Information provided by the expedition company was not sufficiently accessed and considered either prior to or during the trip. Plans for evacuation relied almost entirely upon local agents to find and obtain appropriate facilities. They were appointed without their qualifications being checked or references obtained, and were not given any formal training. There were no arrangements in place for an ambulance with medical equipment and/or personnel to be provided in an emergency, and the facilities at local medical centres had not been assessed.

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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) Preparation

- The school, parents and children were not given sufficient and accurate information to allow them to make informed choices about participation and preparation for the trip. Differences in ambulance and medical facilities in Morocco were not fully explained.

- Risk assessments did not include the risks associated with insufficient fitness and preparation, acclimatisation, and evacuation in the event of a medical emergency.

- Individual participants were not formally assessed as to their fitness for the activity. There was an apparent onus on the parents and participants to assess fitness, though they had no real knowledge or understanding of the environment in which the child would be staying or the activities involved.

- Up to date medical information about the participants was not proactively obtained shortly before departure.

Evacuation:

- Exertional heatstroke and (dependent upon the cause) hyponatremia, are preventable but life-threatening conditions, requiring urgent and appropriate evacuation to advanced medical facilities. In an environment such as the foothills of the Atlas Mountains, the focus is likely be on prevention, because it is clear that urgent evacuation is not usually possible.

- Expedition and school leaders were not given sufficient information and training as to the dangers of heatstroke and hyponatremia, how to recognise the risk of occurrence in a given individual, how to recognise the symptoms and how to manage them if they occurred.

- Procedures and facilities for urgent evacuation were not fully and formally assessed, tested and audited. Arrangements were reliant upon local agencies individuals and facilities which had not been subjected to adequate checking and scrutiny.

NOTE: The expedition company has made a number of changes since Samuel's death, but the purpose of this report is to raise concerns more widely.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe your Department has the power to take such action.

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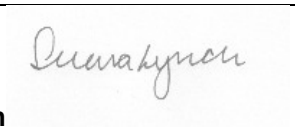
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd April 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you 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 : • [redacted] • World Challenge Expeditions Limited • The Business Academy Bexley • [redacted] and to the LOCAL SAFEGUARDING BOARD I have also sent copies to the Health and Safety Executive, the Royal Geographical Society, and the Medicines and Healthcare products Regulatory Agency (MHRA) 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	 **4th February 2014** **Selena Lynch**