Honesty Equality Accountability Respect Teamwork

Putting **patients** at the **HEART** of everything we do

NHS
London North West University Healthcare
NHS Trust


Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
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1 July 2019

Dear Ms Hassell

**RE: Recommendations following the inquest of Karanbir Singh Cheema concluded on 10 May 2019.**

I write further to the conclusion into the inquest of Karanbir Singh Cheema wherein you raised 12 matters of concerns against nine organisations. Four of those concerns relate to the London Northwest University Healthcare NHS Trust namely:

1. (Point 4 of matters of concern listed in the Prevention of Future Death Report)
   Allergy action plans are not standardized across hospitals and schools, so messages are not as clearly delivered as they could be. This is vital particularly when they may be read for the first time in a desperate situation where panic has set in.

2. (Point 5 of matters of concerns listed in the Prevention of Future Death Report)
   The allergy action plan drafted by Karanbir's doctors at Ealing Hospital did not find its way to his school. There is no standardized approach to this, for example always sending a copy to the school designated safeguarding lead, as well as giving parents / carers a copy for themselves and a copy for the school in case the posted version does not arrive.

3. (Point 6 of matters of concerns listed in the Prevention of Future Death Report)
   Karanbir's treating doctors wanted him to re-attend for asthma and allergy review four months after his last consultation. An appointment was made but cancelled by the hospital. By the time of his death four months later he had still not been seen again. There needed to be a recognition of the time critical nature of this appointment. It needed to be re-booked without delay.

4. (Point 7 of matters of concerns listed in the Prevention of Future Death Report)
   Karanbir had one Epipen at home, one at school and one at his father's home. There is clearly a need for medical teams to emphasise that two EpiPens must be available at all times.

You gave the Trust fifty six days to consider this issue and write to you setting out how the Trust proposes to address your concerns. The Trust has taken your concerns very seriously and has made the following changes:

**1. Standardized allergy care plans**
Following this case, the paediatric allergy leads from Ealing and Northwick Park Hospital advise that they use and advocate the *BSACI Allergy Action Plan for any child with an allergy* – which is printed in colour from clinic and 2 copies are given to parents (one to be kept at home and one for them to share with the school nurse or welfare officer of the school), and this is shared with the GP and a copy is left in the clinical records.

This information has been presented to the Paediatric team in the Departmental Clinical Governance meeting on 26 June 2019.

Education and training of the use and administration of cetirizine and adrenaline auto-injector is given to the child at the same time as the action plan from clinic as point of care after identification of the allergy. To ensure this we will go through the allergy action plans and injection technique with the child (if age appropriate) and the carers in clinic always.

**2. Sharing of the allergy care plan with the school**
I have been advised by the clinicians that the usual practice is training the parent (and child) first and informing them to tell the school of the child's allergy and avoidance of the precipitant. Following Karanbir's inquest, the Trust has added the additional process of posting or emailing each allergy plan to the school in question.

**3. Re-booking cancelled clinics**
The relevant department has been advised that before a clinic list is cancelled (when there are patients already in the list), the clinician is given the list of patients of the clinic who then looks through to see if any of the appointments are "time critical" (as it was in Karanbir's case) and then instructs the secretary or access centre to send out the appropriate alternate date for the next appointment.

**4. Availability of two adrenaline auto-injectors**
The Trust has made changes in that there will be two adrenaline auto-injectors to be kept with the child at all times and two to be kept at the school, so GPs will be asked to prescribe 4 adrenaline auto-injectors . The GP will be asked to prescribe 3 adrenaline auto-injectors if it is known that the school has a generic adrenaline auto-injector for use for any child.

Yours sincerely

**Simon Crawford**
**Deputy Chief Executive**

**On behalf of**

**Jacqueline Docherty DBE**
**Chief Executive**