Regulation 28: Prevention of Future Deaths (PFD) report

Karanbir Singh CHEEMA (died 09.07.17)

THIS REPORT IS BEING SENT TO:

1. [redacted]
   Executive Head Teacher
   William Perkin High School
   Oldfield Lane North
   Greenford UB6 8PR

2. **Dame Jacqueline Docherty**
   Chief Executive
   London North West University Healthcare NHS Trust
   Ealing Hospital
   Uxbridge Road
   Southall UB1 3HW

3. [redacted]
   Medical Director
   London Ambulance Service
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4. **Ms Heather Bresch**
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5. [redacted]
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   British Society for Allergy and Clinical Immunology
   Studio 16
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6. [redacted]
   President
   Royal College of Paediatrics and Child Health
   5-11 Theobalds Road
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   London WC1X 8SH

	7. Professor Dame Sally Davies **Chief Medical Officer for England** **Department of Health and Social Care** **Room 114, Richmond House** **79 Whitehall** **London SW1A 2NS** **8. Mr Matt Hancock MP** **Secretary of State for Health and Social Care** **Department of Health and Social Care** **9. Mr Damian Hinds MP** **Secretary of State for Education** **Department for Education**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 12 July 2017 I commenced an investigation into the death of Karanbir Cheema, aged 13 years. The investigation concluded at the end of the inquest today. I made a narrative determination at inquest, which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Karanbir was attended William Perkin High School. On Wednesday, 28 June 2017, another pupil threw a small piece of cheese at him. He was known to be allergic to cheese and he went into anaphylactic shock.

	His medical cause of death was: 1a post cardiac arrest syndrome 1b anaphylactic shock 1c multiple food allergies 2 bronchial asthma
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. I am aware that some changes have been made since Karanbir's death and therefore do not need to be re-iterated now, but others remain outstanding. Some issues I raised before Karanbir's death, in PFD reports I made in May 2017 following the death of Nasar Ahmed on 14 November 2016. The **MATTERS OF CONCERN** are as follows. 1. The pupils at Karanbir's school had a patchy understanding of his allergies, what they were and the consequences of exposure to allergens. Targeted education about this would improve safety. 2. Karanbir's school care plan and medical box were not checked or audited to ensure, for example, that if his care plan stipulated two EpiPens® (adrenaline auto-injectors), the box contained two EpiPens. 3. Karanbir's EpiPen was out of date. There must be systems in place to ensure that medication in schools is in date. 4. Allergy action plans are not standardised 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. 5. The allergy action plan drafted by Karanbir's doctors at Ealing Hospital did not find its way to his school. There is no standardised 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.

	6. 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 recognition of the time critical nature of this appointment. It needed to be re-booked without delay. 7. 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. 8. There appears to be a lack of awareness nationally of the simple but vital messages that: - if a person with an allergy has been exposed to an allergen and develops any respiratory compromise, so any breathing difficulty at all, then adrenaline (via EpiPen or other) should be administered immediately, before any asthma pump and even before calling for help; - if there is a deterioration after giving one EpiPen, then another should be administered immediately, or in any event after five minutes if there is no improvement. 9. The EpiPen box does not contain these instructions on the outside. 10. These instructions were not communicated effectively as part of the school staff's first aid and EpiPen training. 11. The London Ambulance Service 999 operator did not at any time suggest that a second EpiPen be given, because this is not contained within the algorithm. That could be remedied internationally. 12. The allergy specialist who gave evidence was firmly of the view that generic adrenaline auto-injectors should be available, in much the same way as defibrillators, in public spaces. This was the view of the respiratory physician who gave evidence in May 2017 and about which I wrote then to the Chief Medical Officer for England. Is this worthy of reconsideration?
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 8 July 2019. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • Medicines and Healthcare Products Regulatory Agency • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • Health and Safety Executive • Safeguarding Children Board • Child Death Overview Panel • [redacted], Karanbir's mum • [redacted] Karanbir's dad 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 10.05.19