REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. CCG** **3. Chief Coroner**
1	**CORONER** I am Lydia Brown, Acting senior coroner, for the coroner area of West 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 24 October 2019 I commenced an investigation into the death of Asher William Robert Sinclair, age 3. The investigation concluded at the end of the inquest on 24 January 2022. The conclusion of the inquest was Medical cause of death - 1a Hypoxic Ischaemic Brain Injury 1b Out of Hospital Cardiac Arrest 1c Displaced Tracheal Tube (Trachael tube dependant) II Neonatal enterviral myocarditis and encephalitis (trachael ventilator dependant and cardiac pacemaker) Asher died on 8th October 2019 in Great Ormond Street hospital when his life support mechanisms were withdrawn. Asher Sinclair was entirely dependent on artificial ventilation due to a neonatal brain stem injury and required 24 hour care at a ratio of 2:1 at all times. The parents provided much of this care, but a complex community package was also commissioned and should have been operated to meet his clinical needs. There were deficiencies in the training, planning and oversight of the package of care by both the care agency and the commissioning body. Near misses and warning signs were not escalated appropriately or at all, and the clear problems were not addressed, leaving Asher, his parents and those directly responsible for providing the care in a repeatedly dangerous situation. Reviews at all levels were inadequate, perfunctory and not fit for purpose. On 3rd October 2019 Asher was left in the care of a sole nurse. His tracheostomy tube became dislodged and the nurse failed to follow the emergency procedure or use the full kit that was readily available in the same room. The first aid she did provide was ineffective as she did not secure his airway first. He was deprived of oxygen until the paramedic crews arrived over 9 minutes later and only then was the airway secured. He sustained a hypoxic injury from which he did not recover. Asher's death was a direct and foreseeable consequence of the failings in delivery of his care package. Neglect by the agency, commissioners and nurse

	on duty contributed to this tragic outcome.
4	**CIRCUMSTANCES OF THE DEATH** **See above**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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. – Asher was entirely dependent upon a complex package of care as a highly vulnerable ventilator dependent child. Evidence at inquest was that on numerous occasions he was not provided with the prescribed 2:1 care. The care package, despite being described as one of the most complex and most expensive was not appropriately reviewed and there was no mandatory system of quality checks or formal review when there was a significant change in family circumstances. Quarterly reviews were not carried out without explanation. The primary responsibility fell upon the family members, namely Asher's parents, who were also responsible for other children in the family and employed as teachers. Concerns raised by the parents were not taken for discussion to case conference or professional's meetings and essentially not followed up at all, leaving the situation in the house dangerous with an ultimately calamitous outcome. There was a lack of scrutiny or reconciliation of Asher's care package, which could have identified gaps that needed to be addressed. Training for the staff involved was unclear to the court and seemingly not in place or inadequate. A high turnover of staff was cited as one of the reasons, but this should have highlighted a need for increased training and scrutiny. The court was advised that new structures would be in place by July 2022. The production of this report therefore has been delayed to give the opportunity for those systems to be in place and reported to the court.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 31 October 2022. 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 local safeguarding board where the deceased was under 18 and to the following Interested Persons • Family • First Option Healthcare • CCG – [redacted] 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 other 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.
9	**29th July 2022** **Lydia Brown** **Acting Senior Coroner**