Regulation 28: Prevention of Future Deaths report

Nasar AHMED (died 14.11.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Medical Officer for England** **Department of Health** **Room 114, Richmond House** **79 Whitehall** **London SW1A 2NS**
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 17 November 2016 I commenced an investigation into the death of Nasar Ahmed, aged 14 years. The investigation concluded at the end of the inquest today. I made a narrative determination, which I attach. I concluded that the medical cause of death was: 1a post cardiac arrest hypoxic ischaemic brain injury 1b status asthmaticus 1c anaphylaxis 2 bronchial asthma and multiple food allergies
4	**CIRCUMSTANCES OF THE DEATH** Nasar died following an anaphylactic reaction contributed to by his asthma, when he was in the internal exclusion room at school.

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 **MATTER OF CONCERN** is as follows. The respiratory paediatrician who gave evidence at inquest was firmly of the view that generic adrenaline auto-injectors should be available, in much the same way as defibrillators, in public spaces. Is this a suggestion that could be given wider consideration?
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 14 July 2017. 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 • National Ambulance Service Medical Directors (NASMeD) • Tower Hamlets Child Death Overview Panel • [redacted], allergy paediatrician, RLH • [redacted], respiratory paediatrician, RLH • [redacted], Nasar's parents 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** 12.05.17

Regulation 28: Prevention of Future Deaths report

Nasar AHMED (died 14.11.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD**
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 17 November 2016 I commenced an investigation into the death of Nasar Ahmed, aged 14 years. The investigation concluded at the end of the inquest today. I made a narrative determination, which I attach. I concluded that the medical cause of death was: 1a post cardiac arrest hypoxic ischaemic brain injury 1b status asthmaticus 1c anaphylaxis 2 bronchial asthma and multiple food allergies
4	**CIRCUMSTANCES OF THE DEATH** Nasar died following an anaphylactic reaction contributed to by his asthma, when he was in the internal exclusion room at school.

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 **MATTER OF CONCERN** is as follows. 1. While staff at Nasar's school were waiting for an ambulance, they asked for advice from the call operator about whether to administer his EpiPen. They were put through to a paramedic, who advised not to use it, I think because the classic signs of anaphylaxis were not obvious. However, the firm view expressed to me at inquest by Nasser's respiratory paediatrician was that, if a person has an adrenaline auto-injector and: - has any respiratory compromise, or - there is a loss of consciousness, or - *if there is doubt*, then the correct and potentially lifesaving course of action, regardless of the particular constellation of signs and symptoms, is to use the EpiPen and to use it immediately. He explained that any harm caused by giving intra muscular adrenaline from an auto-injector in this situation is likely to be minimal, even if it proves not to have been needed, whereas the good if it is needed is potentially lifesaving.
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 14 July 2017. 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 • Professor Dame Sally Davies, Chief Medical Officer for England • Medicines and Healthcare Products Regulatory Agency • National Ambulance Service Medical Directors (NASMeD) • Tower Hamlets Child Death Overview Panel • [redacted] allergy paediatrician, RLH • [redacted], respiratory paediatrician, RLH • [redacted], Nasar's parents 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** 12.05.17

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Nasar AHMED (died 14.11.16)

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **Chief Medical Officer** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB** **2.** [redacted] **General Practitioner** **Bromley by Bow Health Centre** **St Leonard's Street** **London E3 3BT** **3.** [redacted] **President** **British Society for Allergy and Clinical Immunology** **Studio 16** **Cloisters House** **8 Battersea Park Road** **London SW8 4BG**
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 17 November 2016 I commenced an investigation into the death of Nasar Ahmed, aged 14 years. The investigation concluded at the end of the inquest today. I made a narrative determination, which I attach. I concluded that the medical cause of death was: 1a post cardiac arrest hypoxic ischaemic brain injury 1b status asthmaticus 1c anaphylaxis 2 bronchial asthma and multiple food allergies
4	**CIRCUMSTANCES OF THE DEATH** Nasar died following an anaphylactic reaction contributed to by his asthma, when he was in the internal exclusion room at school.
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. The picture presented by Nasar to his respiratory paediatrician did not accord, the consultant discovered at inquest, with that given to Nasar's general practitioner. Nasar reported to his consultant that he was experiencing few symptoms, and he did extremely well in his last lung function test. Yet his GP found Nasar's asthma control score to be 14 out of 25, which is poor; and his GP was prescribing 30 inhalers a year, the necessity for which is well recognised as being a risk factor for death. Nasar should have seen his consultant again. There must be a way of identifying a child in his position. For instance, could there be an automatic flag raised if excess medication is prescribed? 2. The asthma pump in Nasar's medication box at school was an Accuhaler, which I heard from his respiratory consultant is inappropriate for an emergency situation such as this, and would not have assisted him. Moreover, the appropriate inhaler should have been accompanied by a spacer for best administration. I wonder whether there is a widespread lack of understanding of the best treatment in this situation?

	3. The school nurse had updated Nasar's care plan by using the *allergy action plan (mild-moderate with asthma)* instead of the correct one used the year before, the *allergy action plan (severe with asthma)*. This meant that Nasar's medication box contained an EpiPen without any description of when or how to use it. There must be a way of ensuring that the care plan is accurate and up to date, and that there are identical copies stored at home, school, the GP surgery and within the hospital records. 4. Even if the correct action plan had been used, it does not give the instruction that if a person has an adrenaline auto-injector and: - has any respiratory compromise, or - there is a loss of consciousness, or - *if there is doubt*, then the correct and potentially lifesaving course of action, regardless of the particular constellation of signs and symptoms, is to use the EpiPen and to use it immediately. This was the very firm view of Nasar's respiratory consultant. Is there a way of disseminating this advice more widely?
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 14 July 2017. 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.
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	• Tower Hamlets Child Death Overview Panel • [redacted], allergy paediatrician, RLH • [redacted], respiratory paediatrician, RLH • [redacted], Nasar's parents 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** 12.05.17

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Nasar AHMED (died 14.11.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Associate Headteacher** **Bow School** **44 Twelvetrees Crescent** **London E3 3QW**
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 17 November 2016 I commenced an investigation into the death of Nasar Ahmed, aged 14 years. The investigation concluded at the end of the inquest today. I made a narrative determination, which I attach. I concluded that the medical cause of death was: 1a post cardiac arrest hypoxic ischaemic brain injury 1b status asthmaticus 1c anaphylaxis 2 bronchial asthma and multiple food allergies
4	**CIRCUMSTANCES OF THE DEATH** Nasar died following an anaphylactic reaction contributed to by his asthma, when he was in the internal exclusion room at school.

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. Although Nasar's mother was present for Nasar's medication review conducted by the school nurse, there was no school representative such as the year learning manager there for the meeting, contrary to school policy.

2. The school nurse identified Nasar's medication as being out of date, and asked that in-date medication be provided, but there was no robust system for ensuring that he was booked in for further review when this was provided.

3. Although all staff at the Bow School were encouraged to familiarise themselves with pupils' care plans, they often did not unless there was a school excursion. The internal exclusion room (IER) supervisor had not done this for the pupils in the IER. Even the deputy headteacher, who had in the past taught Nasar, did not know about Nasar's food allergies or the fact that he had a care plan and allergy action plan when he placed Nasar in the IER.

4. Not everyone involved in trying to help Nasar was first aid trained, most notably not the learning assistant who was supervising the IER. She said that she would not have thought of looking for and retrieving his care plan.

5. Even those members of staff who were first aid trained it seemed might benefit from additional and/or more frequent training. One member of staff did not share with others the fact that Nasar had asked for this asthma pump. Another looked at his individual healthcare plan, but could not remember looking at the allergy action plan.

6. One member of staff forgot Nasar's name. It is of course not possible for members of staff to remember the names of all pupils, but perhaps typed forms accompanied by a photograph might help?

7. Although not followed in this instance, I heard that the school policy dictates that the headteacher's personal assistant should be contacted to telephone the emergency services. Such a stipulation would surely be guaranteed to add delay.

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 14 July 2017. 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 • Professor Dame Sally Davies, Chief Medical Officer for England • Tower Hamlets Child Death Overview Panel • [redacted], respiratory paediatrician, RLH • [redacted], Nasar's parents 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.
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Nasar AHMED (died 14.11.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive Officer** **Compass Wellbeing Tower Hamlets** **Steel's Lane Health Centre** **384-388 Commercial Road** **London E1 0LR**
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.
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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. When the school nurse (employed by Compass Wellbeing) conducted a review of Nasar's medication in May 2016, he did not have the medication stored in school in front of him at the time, but relied on its description by a school receptionist. 2. Although Nasar's mother was present for the review, there was no school representative, such as the year learning manager (head of year), there for the meeting. 3. The school nurse then updated the care plan by using the *allergy action plan (mild-moderate with asthma)* instead of the correct one used the year before *allergy action plan (severe with asthma)*. This meant that Nasar's medication box contained an EpiPen without any description of when or how to use it. 4. He identified the medication as being out of date, and asked that in-date medication be provided, but did not diary forward to the following week to ensure that current medication was now in the box. This meant that he also did not complete the action plan with the dose of the relevant medication. These points raise issues about the actions of this particular nurse and potentially of other nurses in this role in other schools.
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 14 July 2017. 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.

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