	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Secretary of State for Education
1	**CORONER** I am Katrina Hepburn, Area Coroner, for the coroner area of Central & South East Kent
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** On 12th November 2021 I commenced an investigation into the death of Oliver Steeper who was a 9 month old child. The investigation concluded at the end of the inquest on 23rd May 2024. The conclusion of the jury at the inquest was death due to misadventure.

4	**CIRCUMSTANCES OF THE DEATH** Oliver was registered by his parents at Jelly Beans Day Nursery in Ashford. Following a period of "settling in" sessions, he commenced two half day nursery sessions a week from September 2021. At home, his parents had started weaning him from milk to pureed baby food, and he had started to try finger foods. Oliver had two partially erupted bottom front teeth and had no other teeth in his mouth. The family believed that the nursery would be blending and pureeing food for Oliver to eat. The nursery however provided Oliver with finely chopped food at meal times which was different in texture to that which he received at home. At the inquest, evidence highlighted a difference between what Oliver's parents understood he would be fed, and what the nursery provided Oliver to eat. Moreover, evidence identified an apparent lack of knowledge by the nursery staff regarding the different stages of baby weaning, and a lack of knowledge regarding the importance of gathering a child's weaning information from parents, recording that information and circulating it with other staff members. On 23 September 2021, whilst being fed a meal of finely chopped pasta bolognaise at the nursery, Oliver choked and became unconscious. Nursery staff provided initial first aid and an ambulance arrived. Oliver was taken by ambulance to the William Harvey Hospital, Ashford, and was then transferred to the Paediatric Intensive Care Unit at the Evelina London Children's Hospital. A bronchoscopy on 24 September 2021 revealed food debris occluding more than half of Oliver's proximal airway, and present in a number of the small airway branches. Oliver had suffered a hypoxic/ischaemic brain injury due to the cardiorespiratory arrest, which in turn had arisen due to his aspiration of foodstuffs during the choking episode. Oliver's life support was removed, and he died on the 29th September 2021. Expert evidence at the inquest from a Consultant in paediatric, pre-hospital first aid, stated that the level of first aid provided by the nursery staff was overall of a poor standard.

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 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. – 1. Paediatric First Aid (PFA) Requirements I have heard evidence during the course of the inquest that the Early Years Foundation Stage Statutory Framework For Group and School-Based Providers stated that of all the staff on site "*at least one*" member of staff must have a valid paediatric first aid certificate. Whilst I accept that providers could potentially have more, there is a risk that there is only one PFA certified member of staff on site, and that this would still be compliant within the framework mandate. If there is only one PFA certified staff member, they may be solely responsible for providing first aid for all the children on site. If that one staff member is unavailable or indisposed when an emergency situation arises, or simply is unable to render the required first aid by nature of the traumatic events unfolding, this may in turn have a serious and detrimental effect on the child requiring assistance. Other staff members, who perhaps have not had recent PFA training, or staff with no PFA training at all, may have to urgently deal with the evolving situation. There is always a risk that young children, particularly weaning babies like Oliver, will require emergency first aid due to sudden choking. In the 20 years between 2001 and 2021, the Office for National statistics recorded 40 deaths due to choking in infants (children aged less than

one year) in England and Wales.

I am concerned that the Framework does not mandate an increased number of qualified paediatric first aiders to be present on site. I have reviewed the current EYFS statutory framework, published 8th December 2023 and updated 4th January 2024. This contains the same provision as that which was in force at the time of Oliver's death in 2021. See paragraph 3.29.

2. Paediatric First Aid Training Validity Period.

Evidence heard at the inquest was that staff PFA certificates lasted for a period of 3 years before requiring renewal.
The EYFS Framework currently states as follows:
[§3.25]: PFA training must be renewed every three years and be relevant for workers caring for young children and where relevant, babies.

The guidelines for the management of paediatric choking that were current at the time of this incident were published by the Resuscitation Council UK, and this remains the case today.

It was apparent from the evidence heard in this inquest that when confronted with an emergency situation with a choking child, the nursery staff were not able to comply with the Resuscitation Council UK guidelines. The expert stated: "*the first aid care delivered overall was of a relatively poor standard for nursery staff trained and current in paediatric first aid*."
I am concerned that staff with a valid PFA training certificate, may have had the training up to 3 years earlier without having had any refresher training in the interim. They would still be compliant with

	the EYFS statutory framework requirements, but staff may not be able to recall the detail of their training to ensure correct and effective first aid is given, due to the passage of time. 3. Staff Education Regarding Weaning Stages Evidence has been heard during the course of the inquest concerning nursery staffs' understanding of the different stages of weaning that a child moves through. It was not clear that staff appreciated the importance of mirroring weaning at home with weaning at nursery. Staff (and systems) did not appear to ensure that detailed and accurate information about a child's individual weaning stage was elicited from parents, recorded, audited, reviewed and applied. It was not clear that staff appreciated the importance of eliciting and recording this detailed information from the family. Despite staff members having levels 1, 2 and 3 Diplomas in Childcare and Education, there was limited evidence of any knowledge or training on the stages of baby weaning and the risk of a child choking on food. As such, it is not clear that the content of those qualifications adequately covers stages of weaning and how to safely wean in the nursery environment. Even if the training does cover this, it is not apparent that any refresher training is provided to nursery staff holding these qualifications, to ensure that they are up to date in their knowledge, i.e. continuing professional development.
6	**ACTION SHOULD BE TAKEN** I understand that the Department of Education is responsible for creating the Early Years Foundation Stage Statutory Framework, and also is responsible for higher education including the Diploma qualifications in Childcare and Education. I consider that you would have the ability to make any changes to

	the statutory framework with respect to paediatric first aid training requirements for a nursery site, and duration of PFA certificates, and also the content of the Diploma training/refresher training in relation to weaning. In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 23rd July 2024. 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], Jellybeans Day Nursery Representatives, [redacted] and Ofsted. I am also under a duty to send a copy of your response to the Chief Coroner and to 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. She may send a copy of this report to any person who she 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	24th May 2024	 **HM AREA CORONER CENTRAL & SOUTH EAST KENT**