His Majesty's Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Secretary of State for Education, Sanctuary Buildings, Great Smith Street, London, SW1P 3BT [redacted] Director of Policy and Deputy Chief Executive at Local Government Association, 18 Smith Square, Westminster, London SW1P 3HZ [redacted] Traffic Commissioner for West of England, Jubilee House, Croydon Street, Bristol, BS5 0GB
1	**CORONER** I am Katy Skerrett, His Majesty's Senior Coroner for Gloucestershire.
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 the 28th November 2022 I commenced an investigation into the death of Lamarah Grace Scarlett. The investigation concluded at the end of the inquest on the 3 – 5th June 2024. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A Unascertained.
4	**CIRCUMSTANCES OF THE DEATH** Lamarah Grace Scarlett "Lamarah" was a 12 year old girl who suffered with alternating hemiplegia of childhood (AHC) which is characterised by repeated episodes of weakness or paralysis. On the 24th September 2021 she had attended school. Lamarah had appeared happy and well during the day. At the end of the day Lamarah appeared to be tired. Staff did not feel she was presenting with any signs of a seizure or paralysis. At approximately 1500 hours she is secured in her wheelchair by staff and placed on a minibus to be transported to her home address. She is accompanied by a driver and a passenger assistant. During the journey Lamarah appears to be in distress, and is experiencing breathing difficulties. It is probable that Lamarah was suffering from a significant and profound episode of muscle weakness which made her unable to reposition her head to an upright position. Her head was in a hyper extended position, which caused her airway to become obstructed and led to her becoming acutely hypoxic. Neither the passenger assistant or the driver on the bus is aware of this. They do not raise the alarm or seek further assistance. If Lamarah's head had been supported in an upright position and/ or if she had been placed in recovery position, it is likely that her airway would have opened up. However it remains unclear whether this would have enabled sufficient airflow to her lungs as she had significant truncal weakness. At approximately 15.45 hours Lamarah arrives at her home address in an unresponsive state. Her mother commences resuscitation efforts, and emergency services soon thereafter arrive. Despite extensive resuscitation efforts, Lamarah is pronounced deceased at 16.45 hours.

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. – Whether there is sufficient regulation of transport operators who provide category 1 home to school transport services to Special Educational Needs children? The following specific issues were identified: • The patient safety plans are not always read and understood by transport crew, • Home visits between passenger and transport crew often do not occur when contractually required, • The local authority are often not notified of personnel changes in the transport crew, • The need for proper handovers at drop off and pick up is not understood • There is no requirement for transport crew to be qualified first aiders, • The passenger assessment test requires further improvement, • There is no comprehensive schedule for inspection of transport operators, • There is no mandatory training or forums for operators to attend where information can be cascaded to them. • Operators have to approach multiple organisations which leads to confusion and inconsistency.
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 4pm 23rd September 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 (1) [redacted] Senior Associate, HCC Solicitors, New London House, 6 London Street, London, EC3R 7AD (2) [redacted] DAC Beachcroft, Portwall Place, Portwall Lane, Bristol, BS1 9HS (3) [redacted] (4) [redacted] SENT team, Gloucestershire County Council, Block 5, 6th Floor, Shire Hall, Westgate Street, Gloucester, GL1 2TG (5) [redacted] HCR Legal LLP, 62 Cornhill, London, EC3V 3NH 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. 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 by the Chief Coroner.
9	Dated 29th July 2024 Signature_____ Ms Katy Skerrett His Majesty's Senior Coroner for Gloucesrshire

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