REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, The Children's Trust, Tadworth Court, Tadworth, Surrey. KT20 5RU And by email to their legal representatives: [redacted]
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner 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** From 7th April to 9th April 2025 evidence was heard touching the death of Raihana Oluwadamilola Awolaja. She had died on the 1st June 2023 aged 12 years at St George's Hospital, Blackshaw Road, Tooting, London. She had died after she had been left unsupervised in her residential care home, The Children's Trust, Tadworth Court, for approximately fifteen minutes, despite being on one-to-one care for tracheostomy care and other medical conditions and disabilities. Her tracheostomy tube was blocked by secretions and as no carer was present to clear it, she suffered respiratory compromise and arrested. She was resuscitated at the scene but later died of hypoxic brain injury. **Medical Cause of Death** 1 a. Hypoxic ischaemic brain injury 1b Cardiac arrest 1c Post viral respiratory secretions II Pneumonia **How, when, where and in what circumstances the deceased came by her death:** Raihana had been born prematurely at only 27 weeks gestation and as such suffered with significant medical illnesses and disabilities. She was tracheostomy dependent for breathing. She was resident at the Children's Trust (TCT) where she should have received one to one nursing care to safeguard her tracheostomy.

	She had recently suffered viral pneumonia requiring ventilation on PICU and was discharged back to TCT on 23rd May 2023. She was recovering from the pneumonia but still had some increased respiratory secretions requiring an increase in nebulisation therapy and increasing her respiratory vulnerability. On 29/5/2023 her allocated carer left the unit to undertake an administrative task at 19:25-19:30, handing over her nursing care to a nurse due to go off shift. At approximately 19:35, this nurse in turn handed over to another nurse (nurse two) as her shift had ended. Nurse two did not supervise Raihana, instead was caring for another child. At approximately 19:50 Raihana's allocated nurse returned to find that Raihanna had arrested. The alarm was raised, CPR started, and an ambulance called. A return of circulation was achieved at 20:26 and Raihana was transferred to St George's Hospital. Sadly, she died of hypoxic ischaemic brain injury at 19:34 hours on 01/06/2023. Her arrest had been caused by secretions partially blocking her tracheostomy tube. If she had been appropriately observed between 19:35 and 19:50 this would have been recognised and resolved and on the balance of probabilities she would not have died at this time. This failure to adequately observe her was a gross failure in care by the nursing staff. This was compounded by the lack of sufficient staff on the unit where Raihana lived to provide proper 1:1 care. **Final Conclusion:** Natural Causes Contributed to by neglect.
4	**Evidence relevant to the matters of concern.** Extensive evidence was taken and exhibited and some potential regulation 28 matters explored. Of relevance to this report: 1. Raihana's mother raised on a number of occasions that her daughter, contrary to the agreed level of around the clock one to one care, with two to one for personal care, she had observed her daughter to be left with no supervising carer. This was discussed at meetings at the TCT but continued to happen. In particular a written complaint made by Raihana's mother raised this matter and gave a detailed example. This was responded to by TCT by a generic response that Raihana did receive appropriate care without any evidence that the specific example raised was investigated or acted upon. 2. Subsequent to this complaint a member of TCT staff was disciplined in relation to a further occasion when Raihana was left alone, but neither Raihana's named social worker from the London Borough of Croydon, nor Raihana's mother were informed.

	3. There were multiple meetings between Raihana's mother, the named social worker and managers at TCT at which various matters of concern were raised. There was no evidence that these matters nor actions to address them were sufficiently communicated to those caring for Raihana on a day-to-day basis. 4. The carer allocated to look after Raihana at the material time left the unit and went to another unit to fetch a laminator. It was while she was absent that Raihana arrested. 5. Following Raihana's death, TCT undertook an investigation which failed to uncover what had happened or to understand the cause of her death. This meant that a nurse, to whom Raihana's care had been handed to by the allocated carer was blamed by the TCT and was referred to the NMC erroneously. Evidence taken at the inquiry found issues with the credibility of another nurse (nurse two) who should have been caring for Raihana, this responsibility having been handed over to her by the first nurse leaving as her shift was over. This was supported by evidential inconsistencies between witnesses, timing matters and evidence given contemporaneously that should have been evident when TCT investigated. 6. Evidence was taken as to what one to one meant in practice that highlighted for hours every day Raihana would have been on one to two care, once meetings, breaks, handovers, requirement for two to one to be given to other residents, and medication administration etc. was factored in. There were simply insufficient staff to provide constant one to one care, as understood it should have been provided and commissioned by the LA. There was confusion as to what one to one meant at the time of the Raihana's death and how it is practiced now by carers and nurses who gave evidence. There will still be occasions when vulnerable residents such as Raihana will be left one to two, with eyes on only observation, despite an apparent increase in numbers of staff on duty at any one time, albeit it should happen less often.
5	**Matters of Concern** 1. That children such as Raihana requiring one to one care are still at times receiving less intensive care and supervision than they require. 2. That there may be culture of cover up at the TCT, in that they carried out a flawed investigation after this incident, pushing blame onto an innocent individual and thereby avoiding highlighting systemic failures and learning and thus risking lessons that should be learned are lost that could prevent future deaths. 3. That TCT do not sufficiently communicate with the commissioning LA nor next of kin in relation to issues with care and supervision, for example not informing the named social worker nor the mother of the disciplinary proceedings against a staff member who left Raihana alone. This in turn leaves vulnerable residents at risk, as the named social workers and possibly the commissioning authority nor the next of kin will be aware of

	potential increased risks to the vulnerable child. This matter also goes to matter 2 above. 4. That there may be staff training issues in relation to what one to one care means in practice. 5. That there may be training issues in relation to the prioritisation of administrative tasks above care. 6. That next of kin are not sufficiently listened to when they raise concerns, and their complaints are dismissed without sufficient investigation. 7. That the systems of communication between those attending planning and review meetings and those providing care to the residents are inadequate, such that matters raised at these meetings and any actions agreed to address them are insufficiently communicated to those providing care to the residents.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Mother of Raihana, [redacted] (via her legal representatives: [redacted]) Social Services of the London Borough of Croydon (via legal representatives: [redacted]) CQC By email [redacted] HM Coroner for Surrey By email [redacted]

	[redacted] via her legal representatives. NMC 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**2nd May 2025.** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**