Regulation 28: Prevention of Future Deaths report

Rasharn Kirk WILLIAMS (died 23.10.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Headteacher** **Berger Primary School** **Anderson Road** **London E9 6HB**
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 29 October 2014, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Rasharn Williams, aged 9 years. The investigation concluded at the end of the inquest on 24 April 2015, when I made a determination that Rasharn died from natural causes. His medical cause of death was: 1a hypoxia 1b generalised seizure 1c univentricular cyanotic congenital heart disease with pulmonary hypertension

4	**CIRCUMSTANCES OF THE DEATH** Rasharn's cardiologist had not expected him to live to adulthood, but had not expected him to die this quickly. He was a little boy who enjoyed life and engaged with it fully, despite his heart problem. Upon the direction of his doctors and with the agreement of his mother, Rasharn was allowed to participate in school activities, but then to sit out when he felt tired. On 23 October 2014, he was having fun at a school disco when he became fatigued and sat down. He was noticed by a teacher who approached him. He began to cry and was breathless and distressed, so she took him into the school office to sit down. This was at approximately 4.30pm. Rasharn's mother was telephoned and asked to come in to school. After a while, Rasharn appeared to improve a little, and the teacher left him with two members of the administrative staff. One of these was a permanent member who was also a first aider, and one was a more junior, temporary member who was not a first aider but, coincidentally, had looked after a little boy with epilepsy in the past. Approximately seventeen minutes after being brought in to the office, at around 4.47pm, Rasharn deteriorated and became somewhat absent. The junior member of staff suspected him to be having a seizure and asked if an ambulance should be called. The first aider did not think this was a seizure and so formed the view that an ambulance should not be called. Despite the fact that Rasharn had never suffered a seizure before, and was not thought to be particularly at risk of seizures, the likelihood is that this was a seizure from which he never really recovered, and that he later had more seizure activity. His mother arrived three minutes after the seizure began, at around 4.50pm. Four minutes after that, at 4.54pm, the first aider called an ambulance. The ambulance arrived at 5.03pm. While Rasharn was in the back of the ambulance but still on the premises, at 5.14pm, he suffered a cardiac arrest. He was treated and transferred to hospital, arriving at 5.19pm. Rasharn was treated aggressively in hospital, but died later that evening. It is unclear whether earlier medical intervention could have changed the outcome on this particular occasion.

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. Whilst staff at the school were clear that they should call an ambulance in the case of an emergency, and I heard evidence from the first aider that she would have called an ambulance immediately if she had thought Rasharn was having a seizure, Rasharn's care plan was not wholly clear on this point. The plan described breathlessness as an emergency. I appreciate that this may have had its origin with Rasharn's treating clinicians. However, his exercise tolerance was reducing all the time and so breathlessness was, to a degree, a feature of his condition. Extreme breathlessness coupled with low oxygen saturations would be a different matter, but this was not made clear in the plan. This potential lack of clarity did not have an impact on the outcome in this particular situation, but it might in another. It seems that your care plans may benefit from some review to ensure that there is no ambiguity unwittingly created for those attempting to follow them. 2. I heard that some schools have notices with a child's photograph and particular instructions regarding medical conditions, displayed in the staff room, office and medical room. Rasharn did have such a notice, but it was only in the medical room, and was not actually displayed at the time of his death, because of transitional arrangements regarding a move of premises. Again, this did not have an impact on the outcome for him, but might for another child.
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 26 June 2015. 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 Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Rasharn's mother 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** 29.04.15