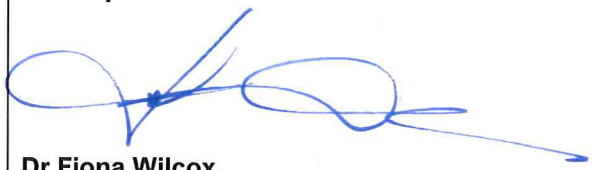
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chair Food Standards Agency,** **Aviation House,** **125, Kingsway,** **London.** **WC2B 6NH.** **The Chief Executive,** **Local Government Association,** **Local Government House,** **Smith Square,** **London.** **SW1P 3HZ.** **Baroness Morgan,** **Chair of Ofsted,** **Ofsted,** **Piccadilly Gate,** **Store Street,** **Manchester.** **M1 2 WD.**
1	**CORONER** I am Dr Fiona Wilcox, 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** On 31st August 2012 I commenced an investigation into the death Miss Tiya Chetan Chauhan aged 22 months. The investigation concluded at the end of the inquest on the 4th September 2014. The conclusion of the inquest found by the jury was: Medical Cause of Death 1 (a) **Cerebral hypoxia** **(b) Asphyxia** **(c) Inhalation of foreign body**

	How, when and where the deceased came by her death: ***Tiya died on 24/08/2012 at St George's Hospital Tooting as a result of cerebral hypoxia caused by an obstruction in her airway. The obstruction was a cube of raw jelly. The cube of raw jelly was out in the sensory tray activity at Dicky Birds Nursery, Dundonald Road on 23/08/12 during nursery set up.*** ***Tiya was able to access the sensory tray during "free flow" time.*** ***The jelly cube was taken form the tray unseen by the nursery staff.*** ***The jelly was inhaled into Tiya's airway unseen by the nursery staff.*** ***Tiya's airway became obstructed and she collapsed unseen by the nursery staff.*** ***Found unconscious on the floor, CPR was administered but she did not regain consciousness and died on 24/08/2012 at St Georges Hospital.*** ***The jury concludes that there was a gross failure on the part of the nursery to provide appropriate care to Tiya. Inadequate communication between all staff led to gross failure of supervision of Tiya which was a significant contributing factor to her death.*** ***The sensory tray activity containing the jelly cube was not adequately risk assessed, neither was it adequately supervised by staff, and for a period of time there was not sufficient supervision of room 3.*** Conclusion of the Jury as to the death ***Tiya Chetan Chauhan died as the result of an accident contributed to neglect.***
4	**CIRCUMSTANCES OF THE DEATH** It was clear from the evidence taken during the inquest that the conforming nature of the raw jelly made it particularly difficult to clear from Tiya's airway once it had formed an obstruction. Small children are at an increased risk of choking due the size of their airway, their incomplete dentition and their tendency to put things in their mouths. The risk of choking from the raw jelly had not been adequately appreciated by the setting, and nor had appropriate supervision been put in place of the sensory activity containing the raw jelly cubes.
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) That nurseries, other childcare and school settings and even parents may be using raw jelly during play without appreciating the especial risks of choking that

	a cube of raw jelly presents. (2) That packets of raw jelly do not contain a warning that cubes of jelly present a choking risk to children. (3) That raw jelly cubes may be used in play with young children without sufficient supervision. (4) That LAs and Ofsted learn lessons from this tragic death and ensure appropriate warnings are communicated to the settings overseen by them and training and inspection is organised and implemented as required to mitigate the risk from raw jelly play.
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 of the parties to whom this Prevent Future Death Report is addressed to identify the matters of concern that they should respond to.***
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th November 2014. 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] [redacted] Kennedys 25 Fenchurch Avenue London EC3M 5AD [redacted] Kennedys 25 Fenchurch Avenue London EC3M 5AD

	[redacted] Plexus Law Peninsular House 30-36 Monument Street London EC3R 8NB [redacted] Plexus Law Peninsular House 30-36 Monument Street London EC3R 8NB [redacted] Plexus Law Peninsular House 30-36 Monument Street London EC3R 8NB [redacted] Legal Services London Borough of Merton Civic Centre London Road Morden SM4 5DX 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	**29th September 2014.**  **Dr Fiona Wilcox,** **HM Senior Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**