REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **Headteacher: George Abbot School**
2. **Chief executive, Surrey County Council**
3. **Department of Transport**
4. **Department of Education**
5. **Director, Greenshades Coach Travel Ltd**

CORONER

I am Karen HENDERSON, assistant coroner for the coroner area of Surrey

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

INVESTIGATION and INQUEST

On 19th November 2014 I commenced an investigation into the death of Christopher James B Sears. The investigation concluded at the end of the inquest on 23rd March 2016. The medical cause of death given was:

1a. Epileptic seizure

My narrative conclusion was: **Natural causes**

CIRCUMSTANCES OF THE DEATH

Christopher was a 13 year old boy who had an intermittent history of epileptic type seizures with four such events over the previous five years. He had a seizure type episode in 2012 and was referred and assessed by a consultant paediatrician with an interest in Neurology. Although no formal diagnosis was made and no treatment instituted, Christopher and his mother were given advice relating to protective measures to take in case of a further event. I also heard evidence that as there was no formal diagnosis it was not possible for the school that Christopher attended to have been put on notice with regards to the possibility of epilepsy or steps to be put in place to protect Christopher, including alerting the bus company responsible for transporting students.

On the 13th November 2014 Christopher had another seizure like event on his way home on the school bus after complaining of cluster headache earlier in the morning before school. The bus driver was alerted by a friend of Christopher's that Christopher had had a 'seizure'. The bus driver was at a junction and so drove for a short distance to safely stop the bus. He went to assess Christopher and gave evidence that at this time Christopher was unresponsive and breathing heavily in his seat. The bus driver did not assist Christopher nor did he contact the emergency services. He returned to the driver's seat and drove on to the next bus stop where he allowed the other pupils on the bus to disembark. At this point he returned to see Christopher who was still unresponsive and slumped over in his seat. The bus driver left Christopher and alighted from the bus and at that point made a phone call to the emergency services in which he commented to them that Christopher was still breathing and had a pulse although I heard evidence from the bus driver that he did not check the pulse.

Before the emergency services attended Christopher's mother arrived having been alerted by the mother of a fellow pupil on the bus. On seeing Christopher slumped in his seat on the bus on his own she believed that he was already dead. On advice of the ambulance services the bus driver removed Christopher from the bus and an off duty policeman commenced cardiopulmonary resuscitation until the ambulance crew arrived. The resuscitation continued throughout the journey to the Royal Surrey County Hospital and also within the hospital

without success and although I accepted the evidence that Christopher had more likely than not died on the bus I confirmed death was at time all resuscitative measures had proven futile on 13th November 2014.

A post mortem was undertaken which was inconclusive but having heard all the evidence I accepted the cause of death was more likely than not to be as a consequence of an epileptic seizure which may cause sudden death in its own right but it could not be excluded that postural asphyxia arising from poor positioning after the seizure may have contributed to Christopher's death.

I also heard evidence that a minimum of ten minutes had elapsed from the time the bus driver had been alerted to Christopher's condition and a 999 call being made by him. No explanation was forthcoming as to the reason for the delay. I heard evidence from the emergency services that the earlier they are called the greater likelihood of survival as would also be the case if basic life support measures such as adopting the recovery position were instituted as soon as it was known that someone was unresponsive. I made no finding of fact as to whether this would have changed the outcome with regard to Christopher on the grounds that there was insufficient evidence but commented that it would have been ideal if the emergency services had been called earlier when it was clear Christopher was unresponsive and BLS measures had been understood and instituted.

I also heard evidence from the police that other than a moral duty to assist there was no legal responsibility or duty of care for a bus driver to undertake resuscitation or assist someone who was unwell. I also heard that there was no requirement for drivers to hold qualifications in Basic Life Support techniques. Nor was there any requirement from private bus companies to teach basic life support techniques to their drivers before tendering for contracts from Surrey County Council locally and nationally despite being the only responsible adult transporting pupils. This is in the face of it being an accepted and mandatory requirement in some European and International countries.

I also heard evidence from Christopher's mother that the school were not in a position to institute any individual care of a student without a firm diagnosis and therefore it was not possible to alert the bus company of any possible concerns relating to any particular student/pupil.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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. There is no requirement for bus companies tendering for contracts from Local Authorities to transport pupils/students to ensure all their drivers have undergone training in Basic Life Support.

2. There is no requirement for drivers transporting pupils/students to hold a Basic Life Support qualification.

3. No protocols were in place to assist a driver as to what to do in an emergency situation whilst driving a bus including the need to call the emergency services at the earliest opportunity.

4. The school were unable to inform the bus company concerned without a formal diagnosis and to put protective measures in place.

5. Basic Life Support training is not taught as a matter of course to young adults in secondary education and is not part of the national curriculum.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Bus Company, Surrey County Council, Department of Transport and Department of Education have the power to take such action.

YOUR RESPONSE
You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th July 2016. I, the coroner, may extend this 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.
COPIES and PUBLICATION
I have sent a copy of my report to the Chief Coroner, Chief Executive Surrey County Council, Chief Executive of Ofsted, the Minister for Education, the Minister for Transport, Royal Surrey County Hospital, and to the following Interested Persons [redacted] (mother), [redacted] (father). I have also sent it to [redacted] Director of Greenshades Coach Travel Ltd, [redacted] (bus driver) [redacted] Headteacher of George Abbot school and [redacted] Consultant Paediatrician who may find it useful or of interest. 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.
DATE: 25th May 2016 **SIGNED:** [signature]