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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>1. [redacted] – **Wychall Lane Surgery**<br>2. **NHS England**<br>3. **Birmingham CrossCity CCG** |
| 1 | **CORONER**<br><br>I am Louise Hunt Senior Coroner for **Birmingham and Solihull** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 09/03/2016 I commenced an investigation into the death of Sydney Mya Neil. The investigation concluded at the end of the inquest 15th July 2016. The conclusion of the inquest was that Sydney died from natural causes. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>Sydney suffered from severe brittle asthma. On 03/03/16 she was taken to her GP after school as she was breathless following a walk at school. She arrived at 15.10 and was seen by the GP at 15.13. She was given two nebulisers. A 999 was made requesting an ambulance at 15.28. Shortly before 15.51 she collapsed and a further 999 call was made. CPR was started by the GP. There was ineffective ventilation due to vomit obstruction and no use of oxygen. No suction was used. The ambulance arrived at 15.59 when she was suctioned and ventilated. She was taken to Birmingham Children's Hospital where she died at 02.20am on 06/03/16. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>(1) Once Sydney collapsed in the GP surgery there was inadequate ventilation for 8 minutes. No suction was used nor was oxygen provided. I am concerned about the level of expertise in GP practices when resuscitation is required and whether they have sufficient equipment to deal with emergency situations. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [redacted] on behalf of Wychall lane surgery have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 September 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the family and to the LOCAL SAFEGUARDING BOARD.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | 15/07/2016<br><br>Signature<br>Louise Hunt Senior Coroner **Birmingham and Solihull** |