| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO:<br>1. Caterlink<br>2. Birmingham City Council<br>3. Al Hijrah School<br>4. Birmingham Community Healthcare NHS Trust |
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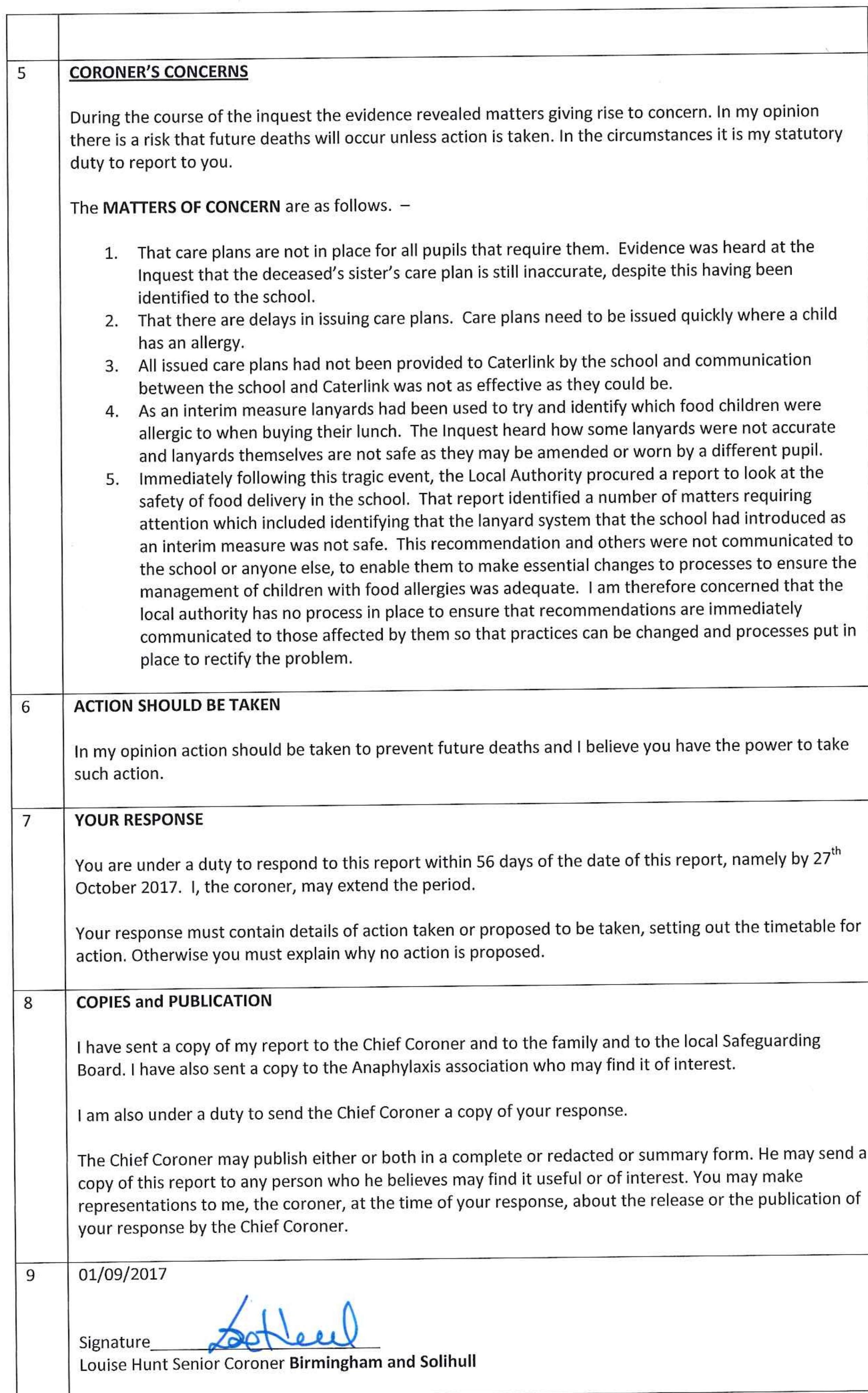
| 1 | **CORONER**<br><br>I am Louise Hunt Senior Coroner for **Birmingham and Solihull** |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 30/03/2017 I commenced an investigation into the death of Mohammad Ismaeel Ashraf. The investigation concluded at the end of an inquest on 24th August 2017. The conclusion of the Jury at the inquest was:<br>"Ismaeel died from an anaphylactic reaction to an undetermined allergen. This is likely to be something he ate. Central issue to the case, we consider to be: 1. There was a failure to recognise the importance of the care plan, and to follow it. 2. The delay in finding and administering the epipen was significant and contributed to his death. This death was contributed to by neglect." |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>The deceased was a 9 year old boy who attended Al Hijrah school. He had a number of allergies which included dairy, nuts and kiwi and possibly fish. He had a care plan in place at school which specified what his allergies were and what treatment was to be provided in the event of a severe allergic reaction. This amounted to piriton for minor symptoms and an epipen in the case of a severe reaction. The epipen was stored in his school classroom. The care plan was clear in stating that the treatment should be brought to the child.<br><br>On 03/03/17 Ismaeel had lunch at 12.33pm which was fish fingers, chips and peas or beans with a capri sun drink – he then went to play and came back to his class at 1.00pm for a maths lesson. At around 1.45pm he complained of stomach ache – a minor symptom of an allergic reaction on his care plan. His teacher thought he was having an allergic reaction to the fish he had ate at lunch. His care plan said he was allergic to fish. He was sent to reception without a staff member where he was given piriton by one of the reception staff. He returned to the class room just before 2.00pm. At this time the children were lining up for prayers. Ismaeel asked to use his inhaler. His breathing was said to be heavier. The teaching assistant said for him to use his inhaler and then told the teacher. The teacher took him to reception where he left Ismaeel with the reception staff and another teaching assistant from a different class before going to prayers. An ambulance was called at this time by the reception staff. Whilst in reception the CCTV shows him deteriorating over a 15 minute period. At one point he states to staff that he thinks he is going to die. Despite this he did not receive his epipen injection as specified in his care plan. An ambulance arrived at 14.13 and administered the epipen which staff had previously had difficulty finding. Despite treatment Ismaeel went into cardiac arrest and attempts to resuscitate him were unsuccessful resulting in his death later that day at Birmingham Heartlands Hospital.<br><br>Following a post mortem, the medical cause of death was determined to be:<br>ANAPHYLACTIC REACTION CAUSED BY AN UNDETERMINED ALLERGEN |



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 care plans are not in place for all pupils that require them. Evidence was heard at the Inquest that the deceased's sister's care plan is still inaccurate, despite this having been identified to the school.
2. That there are delays in issuing care plans. Care plans need to be issued quickly where a child has an allergy.
3. All issued care plans had not been provided to Caterlink by the school and communication between the school and Caterlink was not as effective as they could be.
4. As an interim measure lanyards had been used to try and identify which food children were allergic to when buying their lunch. The Inquest heard how some lanyards were not accurate and lanyards themselves are not safe as they may be amended or worn by a different pupil.
5. Immediately following this tragic event, the Local Authority procured a report to look at the safety of food delivery in the school. That report identified a number of matters requiring attention which included identifying that the lanyard system that the school had introduced as an interim measure was not safe. This recommendation and others were not communicated to the school or anyone else, to enable them to make essential changes to processes to ensure the management of children with food allergies was adequate. I am therefore concerned that the local authority has no process in place to ensure that recommendations are immediately communicated to those affected by them so that practices can be changed and processes put in place to rectify the problem.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe 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 27th October 2017. 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 family and to the local Safeguarding Board. I have also sent a copy to the Anaphylaxis association who may find it 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.

9 01/09/2017

Signature____________

Louise Hunt Senior Coroner **Birmingham and Solihull**