REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Lambeth Children Safeguarding Board, London Borough of Lambeth, PO. Box 733, Winchester SO23 5DH; Email: [redacted]** **2. The South London Islamic Centre, 8 Mitcham lane, London SW16 6NN** **3. The Chief Coroner**
1	**CORONER** I am Lorna Tagliavini, assistant coroner, for the coroner area of Inner London, South.
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 29th January 2018 I commenced an investigation into the death of Yunis Malik Hadi aged 6 years. The investigation concluded at the end of the inquest on 19th June 2018. The conclusion of the inquest was Accidental Death due to 1(a) Airway obstruction following choking with foreign body.
4	**CIRCUMSTANCES OF THE DEATH** On 28th January 2018, Yunis was attending a Sunday school to learn Arabic at the South London Islamic Centre run by volunteer members of the Centre. After classes had finished at around midday, Yunis ate the snack he had brought with him from home while unsupervised and waiting to be collected from the Centre. Yunis chocked and collapsed and despite extensive CPR efforts by members of the Centre and the LAS, he could not be resuscitated and life extinct was declared at St George's Hospital, London.
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) A lack of formal training among the adult volunteers/teachers in first aid including response to choking incidents. (2) A lack of emergency medical equipment i.e. a defibrillator. (3) A lack of oversight to ensure first aid emergency training, supervision and child safeguarding is kept up to date and in place at all relevant time.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. Although the Centre has told me at the inquest of steps they have taken or are going to take to prevent similar occurrences, it is

	my opinion that tour organisation has the authority to ensure the proposed changes by the Centre are implemented and kept up to date.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th August 2018 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 Lambeth Safeguarding Board and the South London Islamic Centre as well as to [redacted] the mother of Yunis. 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	**30th June 2018** **Lorna Tagliavini, Assistant Coroner**