



**M. E. Voisin**  
**Her Majesty's Senior Coroner**  
**Area of Avon**

20th May 2021



	<b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b> <b>THIS REPORT IS BEING SENT TO: The Secretary of State for Education</b>
1	<b>CORONER</b>  I am M E Voisin Senior Coroner for <b>Area of Avon</b>
2	<b>CORONER'S LEGAL POWERS</b>  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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	<b>INVESTIGATION and INQUEST</b>  On 20/05/2020 I commenced an investigation into the death of Anastasia Ekaterina UGLOW. The investigation concluded at the end of the inquest 14th May 2021. The conclusion of the inquest was ...  Anastasia Uglow died on 19th December 2019 at Mount Sinai Hospital, New York. She was in New York on a school trip from her home in Bristol. She had been unwell in the days leading up to the trip, but became worse as the days progressed. She had influenza with pneumonia and group A streptococcus. On 18 <sup>th</sup> December 2019 she participated in the trip in the morning, went shopping in the afternoon and went on a trip to the Empire State Building in the evening. On 19 <sup>th</sup> December 2019 in the morning she woke in septic shock; she collapsed in cardiac arrest; the emergency services were called but she died when she arrived at the hospital.
4	<b>CIRCUMSTANCES OF THE DEATH</b>  Ana had been unwell before her trip with the school but it was when she was on the trip in New York when she became more unwell. To those around her she had cold/flu like symptoms. It was reported that she told the teachers on the trip about not feeling well. She had sepsis, deteriorated and collapsed in her hotel room.
5	<b><u>CORONER'S CONCERNS</u></b>  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 <b>MATTERS OF CONCERN</b> are as follows. –



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The Coroner's Court, Old Weston Road, Flax Bourton, BS48 1UL

In this case it became clear that Ana's school is already taking the step to include within their first aid training for staff – sepsis awareness.

This case clearly demonstrates how awful this condition is and how tragic the consequences are if it left untreated.

My report is therefore written to consider raising sepsis awareness within all schools.

At the conclusion of the inquest I requested that Ana's school provide any additional information which may assist with this and they have emailed the following ....

"I wonder if you would be kind enough to pass this email to H M Senior Coroner. It is response to her request that BGS (*Bristol Grammar School*) assist in relation to her proposed PFD report to raise awareness of sepsis in schools.

We respectfully submit that the Coroner should write to the Secretary of State for Education and ask him to draw the attention of the DfE Health and Safety team to her proposed PFD report. ..


The ability of a healthy teenager to compensate for sepsis symptoms is frightening and BGS is determined to do all it can to raise awareness of this issue with the aim of preventing any future tragedies.

Andrew Dimberline has secured the agreement of the Outdoor Education Advisers' Panel (OEAP) and the UK Sepsis Trust that they will produce a guidance document on SEPSIS awareness and add this to the OEAP National Guidance website (<https://oeapng.info/>) .

[REDACTED] (the Headmaster of BGS) and [REDACTED] (BGS staff first aid trainer) are currently liaising with the UK Sepsis trust. Dr [REDACTED] of the Sepsis Trust and Dr [REDACTED] have met recently and discussed the nature of this guidance and have also suggested that in addition to written guidance they will produce a short video for use in training School staff and there will be a link to this in the OEAP guidance document.

BGS will fund the production of this guidance by donation to the UK Sepsis Trust and the ongoing cost of keeping it updated through an annual contribution to the OEAP. The OEAP guidance document will be produced and available to Schools for the start of the Autumn Term 2021. We are looking to launch the guidance to coincide with World Sepsis day on 12 Sept 2021 in order to gain the maximum publicity. We would hope that the OEAP guidance document will then be something the DfE and other organisations could then to 'signpost to' in their own advice. DfE Health and safety Guidance for School visits currently signposts to OEAP Guidance in general – see point 8 in <https://www.gov.uk/government/publications/health-and-safety-on-educational-visits/health-and-safety-on-educational-visits> OEAP guidance is also endorsed by the HSE (see <https://oeapng.info/endorsements/>)

BGS will promote the guidance document to Independent School organisations – HMC, ISC, GDST, ISBA. The OEAP will promote the new guidance to all Schools through its twitter and facebook accounts and the network of advisers to maintained schools and the UK Sepsis Trust will promote it through a campaign. "

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 19<sup>th</sup> August 2021. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the chief coroner and to the following interested persons – the family, Bristol Grammar School, [REDACTED] and [REDACTED] and to the Local Safeguarding Board</p> <p>I am also under a duty to send the chief coroner a copy of your response.</p> <p>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.</p>
9	<p>24/05/2021</p> <p>Signature </p> <p>M E Voisin Senior Coroner Area of Avon</p>