## **Regulation 28: Prevention of Future Deaths report**

Alaynah <u>Khadija</u> AHMED (died 08.07.21)

	THIS REPORT IS BEING SENT TO:		
	1. Principal Swiss Cottage Special School 80 Avenue Road London NW8 6HX		
1	CORONER		
	I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP		
2	CORONER'S LEGAL POWERS		
	I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.		
3	INVESTIGATION and INQUEST		
	On 9 July 2021, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Khadija Ahmed, aged 6 years. The investigation concluded at the end of the inquest yesterday. I made a determination at inquest that death arose from natural causes.		
	The medical cause of death I recorded as follows. 1a hypoxic brain injury		
	1b out of hospital cardiac arrest secondary to mucous plugging 1c spinal muscular atrophy type 1		
4	CIRCUMSTANCES OF THE DEATH		
	Khadija suffered a cardiac arrest whilst at school on 1 July 2021. This caused a hypoxic brain injury from which she died a week later.		

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.

I heard that the teaching assistant looking after Khadija was not trained by the school in cardiopulmonary resuscitation and that, when Khadija became unresponsive, CPR was not attempted by any staff member. It is highly unlikely that CPR would have changed the outcome for Khadija. The cause of her cardiac arrest was an airway compromised by mucous plugging, that even a highly trained paramedic crew was unable to clear. However, CPR might make a difference for another child, or even for a staff member.

To put the lack of CPR in context, the care that Khadija received from the school before the arrest seemed to be of a very high standard, even drawing comment from a paediatric intensive care consultant giving evidence at inquest. He told me that many nurses at Great Ormond Street Hospital would not have been able to administer the treatment that Khadija's teaching assistant did on 1 July 2021. She was quick to recognise that something was wrong and quick to act appropriately.

However, it seems to me that the school would benefit from consideration being given to frequent CPR training.

## 6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 31 January 2021. 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 following.		
	<ul> <li>Khadija's parents</li> <li>Medical Director, Royal Free Hospital</li> <li>Chief Executive, London Ambulance Service</li> <li>Medical Director, Great Ormond Street Hospital for Children</li> <li>HHJ Thomas Teague QC, the Chief Coroner of England &amp; Wales</li> </ul>		
	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.		
	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.		
9	DATE	SIGNED BY SENIOR CORONER	
	02.12.21	ME Hassell	