IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Connor Samuel Timothy Wellsted
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **Chief executive, NHS England** • **Mr Sajid Javid, Health Secretary, Department of Health** • **Chief Executive, Children's Trust, Tadworth** • **Medical Director, Children's Trust, Tadworth** • **CQC** • **CCG – Sheffield**
1	CORONER Dr Karen Henderson, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST On 29th March 2022 I recommenced an investigation into the death of Connor Samuel Timothy Wellsted. On the 31st March 2022 I concluded the Investigation. The medical cause of death given was: 1a. Obstruction of the airway through external compression I determined that Connor Samuel Timothy Wellsted died at 08.42 hours on 17th May 2017 following entrapment by a loose cot bumper causing death by way of airway obstruction. I am satisfied that the Children's Trust failed to

	1. Properly secure the cot bumper appropriately and in so doing 2. Failed to keep Connor safe in his cot
1.	CIRCUMSTANCES OF THE DEATH Connor was a five-year-old boy who had significant neuro-disabilities arising from a hypoxic brain injury after a near sudden infant death syndrome (SIDS) cardiorespiratory arrest when he was five weeks of age. On the 18th April 2017, accompanied by his foster parents, Connor attended the Children's Trust, Tadworth for the second time, for a 6 week residential period of intensive neuro-rehabilitation. Connor was doing well and had no significant underlying physical or medical concerns during his stay. On the 16th May 2017 he followed his normal bedtime routine and was put to bed in his padded cot. He was found unexpectedly deceased in his cot on the morning of 17th May 2017. When found, Connor was sitting on the far side of his cot with a padded board from the cot entrapping him upright. Rigor mortis was present. Connor was known to be an active boy and it is likely he had woken, stood up and held onto the cot bumper which was not fixed at the top edge which then became dislodged entrapping him across his neck.
5	CORONER'S CONCERNS 1. The cot The cot Connor's was allocated was nine years old, used infrequently and had not had a yearly servicing for the previous five years. There was no guidance or clarity as to how the padded boards/cot bumper should have been placed around the wooden frame of the cot in circumstances whereby the foster parents did not wish the cot to be padded. It is likely the padded board (1m long, 40 cm wide with a soft side and a rigid side) was inappropriately and inaccurately placed on the wooden frame of the cot and as its top edge was without Velcro it could not have been attached to the cot leaving it loose with the result that it dislodged entrapping Connor across his neck. 2. Monitoring of Connor during the night:

Connor had no regular or direct visual supervision during the night (other than to open the door of his room to check if there was a smell) despite the request of his foster parent to check in circumstances whereby in other parts of the Trust regular visual inspection was the norm.

3. Probity and Investigation by the Children's Trust, Tadworth

The Police and the coroner's service attending the Trust shortly after being informed of Connor's death were not fully informed of the circumstances of his death. The scene had not been preserved. They were not told of the position Connor was found, that he had been dead for some time (likely hours) or that the padded board was initially found across his neck and that it required force by either one or two nurses for it to be pushed down to be removed.

Connor's death was sudden and unexpected, and the senior management of the Trust (chief nurse and medical director) were concerned at the time the role the padded board may have played in Connor's death. However, they did not keep a copy of Connor's medical records, nor did they undertake their own initial internal enquiries, or inform the relevant statutory bodies of their concerns. Furthermore, they arguably misled the CQC as to the circumstances of Connor's death.

Likewise, the pathologist who undertook the autopsy on Connor was not informed of the circumstances of his death thereby preventing a forensic post-mortem to have taken place to establish the role the cot bumper may have played in his death. In addition, the Trust engaged an expert opinion from a forensic pathologist without fully informing him of the position the cot bumper may have played in Connor's death.

The Trust undertook several Serious Investigation reports, the first of which was six months after Connor's death. These reports did not acknowledge or address the role the cot bumper may have played in Connor's death despite evidence from multiple witnesses indicating it was likely to be significant.

4. Senior management, Children's Trust, Tadworth

The current senior management team have not acknowledged there was a lack of transparency and openness as to how Connor died, or that the Trust did not properly investigate his death or inform the relevant statutory bodies of the circumstances of his death giving rise to concern

	of an ongoing lack of insight that institutional learning around serious incidents has not been accepted by the Trust. As a consequence, there is a need to introduce and develop robust clinical governance processes and systems to reassure the public and supervisory statutory bodies that they will be informed of any future adverse events and they will be investigated with openness, candour and transparency.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. [redacted] 4. [redacted] 5. Chief Executive, Sheffield City Council In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: Karen Henderson

	DATED this 15th Day of May 2022