

This is a brief summary of the regulation 28 coroners report into the death of *Nasar Ahmed* from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

## Clinical summary

14-year-old boy with a history of asthma and multiple food allergies

### Events surrounding death

- Nasar died from a hypoxic ischaemic brain injury due to cardiac arrest from status asthmaticus and anaphylaxis whilst internal exclusion room at school
- EpiPen not administered on paramedic advice
- Accuhaler in school medication box with no spacer
- Incorrect asthma/allergy care plan held by school.

## Coroner's Recommendations

- Consider provision of generic adrenaline auto-injectors in public spaces (akin to provision of defibrillators).
- Better dissemination of advise to use a persons adrenaline auto-injector if any signs of respiratory compromise or any doubt.
- Accurate care plans shared with school, home, GP & hospital with in-date, appropriate medicines & devices

## Key Themes

- Need to improve information sharing between clinicians and those who care for a child.
- Care plans need to be accurate & up to date
- Need to improve professional and public understanding of correct use of medicines and devices like inhalers, spacers and adrenaline autoinjectors.

## Local Improvement Activity Suggestions:

- Review your asthma care plans & how they are explained to patients and shared with relevant carers including schools. Is the updating process robust?
- Education program for correct use of devices like spaces/adrenaline autoinjectors for families & clinicians.
- Consider local campaign for provision of generic adrenaline auto-injectors in public spaces

For full information visit  
<https://www.judiciary.uk/prevention-of-future-death-reports/nasar-ahmed-prevention-of-future-deaths-report/> or  
follow the QR code

