REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Resuscitation Council (UK)** **5th Floor** **Tavistock House North** **Tavistock Square** **London** **WC1H 9HR**
1	**CORONER** I am HENRIETTA HILL QC, Assistant Coroner, for the coroner area of Inner South District of Greater London.
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** **ROSEMARIE DEES**, then aged 57 years, died on 18 April 2016. An investigation into her death was opened and an inquest held on 19 July 2016. The inquest heard that Ms Dees had choked on a boiled sweet. The medical cause of Ms Dees' death was asphyxia caused by a food bolus in the larynx. The conclusion of the inquest was one of accident.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows: (1) Ms Dees had a range of pre-existing health conditions including COPD. There was evidence that this led to her often having a dry mouth/throat and coughing a lot. (2) Late in the evening of 18 April 2016 she was at home. Her son heard her banging loudly on the floor. He went to her and found her apparently choking on something. She lost consciousness. Her son began CPR and called the London Ambulance Service ("LAS") who attended. The first LAS staff member arrived on scene at 00.03 am. (3) One of the LAS Paramedics used a Supra-Glottic Airway ("SGA") (an I-Gel) to manage Ms Dees' airway. (4) An Advanced Paramedic ("AP") arrived and found that the SGA was ineffective, so she removed it. Upon removing the SGA the AP noticed a red, sticky, sweet-like substance stuck to the anterior aspect of it. (5) A further SGA was inserted followed by an Endo-Tracheal Tube using a video laryngoscope. (6) Advanced life support continued for 50 minutes. (7) Ms Dees' life was pronounced extinct at 01.14 am.
	<u>CORONER'S CONCERNS</u> 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 that the use of an SGA may be inhibited by an undetected foreign body airway obstruction. Such an obstruction might be spotted if the use of an SGA was made conditional on the carrying out of a laryngoscopy which it is understood will soon be LAS protocol.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14 September 2016. 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 following Interested Persons: the family of Ms Dees and LAS. 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	**Signed .....*Henrietta Hill QC*.....** **Assistant Coroner**