Regulation 28: Prevention of Future Deaths report

Najeeb Katende (died 10.10.2016)

	THIS REPORT IS BEING SENT TO: **Mr Andrew Grimshaw** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD**
1	**CORONER** I am: Edwin Buckett Assistant 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** Following the death of Master Najeeb Katende, aged 15 years, on the 10th October, 2016 an investigation into his death was carried out which concluded at the end of the inquest on 10th April, 2017. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** At about 10am on the 10th October, 2016 Najeeb collapsed at school. A paramedic from LAS attended and was with Najeeb by about 10.12am. The paramedic considered that Najeeb was in cardiac arrest and used at LP15 defibrillator on him in manual mode. He interpreted the readings from that device as showing that Najeeb had a non-shockable heart rhythm and did not defibrillate him. At about 10.36am, a subsequent heart rhythm check was carried out by

	an Advanced Paramedic (who had by then attended the scene) which showed that Najeeb had, in fact, a shockable rhythm. He was then defibrillated 6 times but was pronounced dead at 11.46am at hospital. The data from the LP 15 device was downloaded and analysed. It showed that Najeeb had a shockable rhythm when first tested at 10.12am. Accordingly, Najeeb was not defibrillated for a period of about 24 minutes between 10.12am – 10.36am. The medical cause of death was found to be Sudden Cardiac Death Syndrome. I found that the delay in defibrillating Najeeb significantly reduced his chances of survival although I did not find, on the balance of probabilities that he would have survived had this been done earlier.
5	**CORONER'S CONCERNS** 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. 1. Evidence was given by [redacted] (Consultant Paramedic) that: • Based on LAS statistics the survival rate from cardiac arrest, where there is a shockable rhythm is around 31% when defibrillation occurs; • This is to be contrasted against a survival rate of around 9% for all presenting rhythms; • For every minute of cardiac arrest where a shockable rhythm is present and no defibrillation is carried out, survival decreases by approximately 7-10%. 2. Evidence was also given from other Ambulance staff that: • Despite the presence of other staff between 10.12am and 10.36am, no cross check was made as to whether Najeeb had a shockable rhythm; • If an Automated External Defibrillator, such as those used by members of the public had been applied, this would have detected a shockable rhythm and would have proceeded to defibrillate Najeeb. 3. I consider that it would be of great benefit if LAS were to take the

	following steps, namely training and instruction to staff to: • Actively cross check with another clinician whether a shockable rhythm is present when attending an incident of this sort; • Use the defibrillator in AED mode when first attending as a matter of routine, or at the very least if uncertain when interpreting a heart rhythm; • Further educate on the interpretation of shockable rhythms from readings provided by defibrillator devices.
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 **17th June, 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England and Wales; • [redacted] QAM, Chairman of Association of Ambulance Chief Executives 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	**DATE 21st April, 2017 SIGNED BY ASSISTANT CORONER EDWIN BUCKETT**