REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Secretary of State for Health, DoH • Secretary of State for Transport, DoT Copied for interest to: • Family of the deceased • Chief Coroner
1	**CORONER** I am Fiona Borrill, H.M. Area Coroner for the area of Manchester City.
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	**INQUEST** The deceased, **Lucy Francesca Goldstone**, DoB 4.10.1997 died on 7 April 2016 at Manchester Royal Infirmary. I dealt with the inquest into her death on 24 February 2017 and recorded the pathological cause of death as: 1a Bronchial asthma and aspiration of food material
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of chronic asthma had a severe asthma attack and became unresponsive on a tram in Manchester City centre shortly after boarding at approximately 22.15hrs on 7 April 2016. By-stander Cardio Pulmonary Resuscitation (CPR) was carried out. North West Ambulance Service attended and administered CPR in accordance with Advance Life Support protocols. The deceased was transferred to Manchester Royal Infirmary where despite further CPR death was confirmed at 23.29hrs. I returned a Natural Causes Conclusion.
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: I heard from a witness who was the Safety Health and Environment Manager for Metrolink RATM DeV Limited (MRDL) who at the time of this incident was contracted by Transport for Greater Manchester to operate the tram network known as Metrolink that covers the Greater Manchester area. I was informed that in relation to the availability of Automated Electronic Defibrillator that no AEDs are provided on any of the trams or at

	any of the tram stops on the network, and that it is not a legal requirement or industry standard practise for AEDs to be available across the various tram networks in the United Kingdom. I was also informed that some of the larger rail and bus stations now have AEDs available and that in the absence of a Defibrillator the process in an emergency is to contact the emergency services immediately. In this case there was no evidence that the present of a Defibrillator on the tram would have made a difference to the outcome on the balance of probabilities, however at the conclusion at the inquest I indicated that I would submit a Regulation 28 report to the Department of Health and the Department of Transport to be updated as to the current provision and guidance as to the availability of AEDs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 **Friday 21 July 2017**. 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 Interested Persons. I have also sent it to organisations who may find it useful or of interest. 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:** **NAME OF CORONER:** **26 May 2017** **Fiona Borrill, HM Area Coroner** **Manchester City Area**