REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Emirates via DLA Piper Solicitors • Secretary of State for Health, Department of Health Copied for interest to: • Chief Coroner • Family of deceased • Manchester Airport Group • North West Ambulance Service
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, **Anthony William McCormack**, DOB 080/3/1959, who died on 02/06/2015 at Wythenshawe Hospital. I dealt with the inquest into his death on 04/07/16, 11 and 12/04/2017 and 05/05/2017. I recorded the pathological cause of death as: 1a Myocardial ischaemia 1b Coronary artery atherosclerosis
4	**CIRCUMSTANCES OF THE DEATH** On 02/06/2016 the Deceased boarded Emirates Airlines Flight EK020 at Manchester Airport, destination Dubai, and was seated at 47C. Whilst the aeroplane was taxing along the runway prior to take off, the Deceased became unwell and collapsed in his seat at 21.17hrs. He was assisted by airline staff and was transferred to the galley area for ongoing assessment and management, having communicated prior to transfer that he wished to vomit. He was initially treated as a fainting passenger He was placed in the recovery position, given oxygen and his breathing monitored. The Deceased was groaning and making noisy random sounds indicating abnormal breathing and his condition deteriorated rapidly on arrival to the galley. At 21.27hrs the Captain was alerted to the ongoing medical incident and the aeroplane taxied back to the stand arriving at 21.32hrs. The Tempus device, which monitors and record vital signs, indicated that for a period of 6 minutes and 23 seconds, from 21.25:26, blood pressure and pulse parameters were engaged.

	North West Ambulance Service had been alerted to the incident and a sole paramedic attended the scene at 21.35 hrs The Deceased was lying on the floor in the recovery position and he noted that the Deceased was unconscious with no sign of breathing or palpable pulse. An AED was already attached to the deceased advising no shockable rhythm. No bystander Cardio Pulmonary Resuscitation (CPR) was being administered. The paramedic carried out Basic Life Support and following the arrival of colleagues from the Manchester Airport Fire Service and NWAS, Advanced Life Support was commenced. The Deceased was transferred by ambulance to Wythenshawe Hospital remaining in asystole throughout. Further Advanced Life Support was carried out at Wythenshawe Hospital. Resuscitation ceased and death was confirmed at 22.50hrs. At the end of the inquest I returned a Narrative Conclusion namely that the deceased died of natural cause; however, the rapid deterioration into cardiac arrest and the consequent seriousness of his condition was not fully recognised and CPR not commenced promptly prior to the arrival of the first paramedic. On the evidence earlier institution of CPR would not have prevented the deceased's death.
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: **Emirates Airline :** • The adequacy of the training of Emirates staff in respect of the recognition of possible cardiac arrest and signs thereof including agonal breathing and the administration of appropriate first aid/prompt CPR • The adequacy and effectiveness of the procedures followed by Emirates staff in the event that the Tempus system is unable to provide assistance which was the case here. **Department of Health** • I heard evidence that NWAS failed to meet target times which are nationally set by the Department of Health and that although NWAS was given more financial resources in November 2015 (for provision of more ambulances and recruitment of an additional 400 staff) I was also informed since April 2017 none of the nationally set targets have been met by any ambulance trust in England and Wales namely, a Red 1 response within 8 minutes 75% of the time, Red 2 within 19 minutes 95% of the time, I was also informed that there has been a massive increase of calls to 999 with consequent impact on response times and delays in ambulance turnaround at hospitals.

	• Consequent on the above and in this specific case there was only one paramedic on duty at any one time for the whole of Manchester Airport. Such paramedic being required to carry out Basic Life Support alone and unable to start Advanced Life Support.
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 **Tuesday 7 November 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	**Monday 4 September 2017.** **Ms Fiona Borril, HM Area Coroner, Manchester City Area**