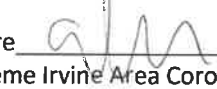
East London Coroners
Mr Graeme IRVINE
AREA CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF: 10602

12th March 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Anthony Marsh, The AACE, MBF, GG322, 30 Great Guildford Street, London, SE1 0HS 2. Garrett Emmerson, Chief Executive London Ambulance Service NHS Trust, 220 Waterloo Road London SE1 8SD. 3. Matt Hancock, Secretary of State for Health and Social Care, Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU. 4. Prof Jonathan Wyllie, Resuscitation Council (UK) 5th Floor, Tavistock House North, Tavistock Square, London, WC1H 9HR. 5. Physio-Control UK Ltd | Hambridge Road | Newbury | Berkshire | RG14 5AW | United Kingdom
1	**CORONER** I am Mr Graeme Irvine, Area Coroner for **East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12th April 2019 HM Senior Coroner commenced an investigation into the death of Mitica Marin. The investigation concluded at the end of the inquest before me on 12th March 2020. I arrived at a narrative conclusion; *"Mr Mitica Marin was found unresponsive at home on the evening of 11th April 2019, despite emergency medical assistance he could not be resuscitated and his death was declared at 21.03 hrs. in hospital. It has not been possible to determine the cause of his cardiac arrest."* The medical cause of death was: *1a Unascertained*

4	**CIRCUMSTANCES OF THE DEATH** Mr. Marin, 35, was found prone and unresponsive at home. The London Ambulance Service ("LAS") was called at 19.06 and arrived promptly at the scene at 19.12. On arrival, Paramedic A noted that CPR was not being performed. Cardiac arrest was confirmed, further resources were dispatched and resuscitation procedures were commenced. After over an hour of advanced life support, at 20.31hrs, Mr. Marin was taken to hospital by ambulance, where his life was pronounced extinct at 21.03hrs. Despite a post mortem examination and a toxicological screen, the cause of death was unascertained.
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. – The LAS serious incident investigation identified a 4-minute delay between LP15 defibrillator pads being placed on Mr Marin's chest and the administration of the first shock. During this period Mr Marin's heart was in a shockable rhythm. Paramedic A accepted that they had not reviewed the defibrillator as they were distracted by events. Paramedic A did not activate the defibrillator in "automatic" mode. Had this setting been applied, any shockable rhythm would have been detected and an alert would have prompted the paramedic to shock to the patient. This is not an isolated incident, the LAS conceded that it had undertaken a review of similar cases of delayed defibrillation. The review found that a factor was that the LP15 defibrillator model, defaults to manual mode requiring the user to switch to automatic mode before use. 2 studies cited by the LAS indicated that every minute a patient is delayed effective resuscitation; their prospects of survival diminishes by between 10-22%. The LAS have introduced remedial measures to prevent such actions occurring, incorporating; training on the use of the LP15, labelling on units and the issuing of revised guidance. If the LP15 defaulted to automatic mode or on start-up required, the choice of manual or automatic mode it is possible that such delays could be avoided. I understand that procurement decisions regarding the future supply of defibrillators are imminent.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **7th May 2020**. 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. 1. The Marin Family 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	12/03/2020 Signature  Mr Graeme Irvine Area Coroner **East London**