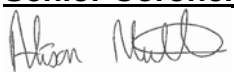
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: NHS England
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 On 16th January 2020 I commenced an investigation into the death of Jack Goodwin. The investigation concluded on the 21stJanuary 2021 and the conclusion was one of narrative: Died from the complications of a hypoxic brain injury that had occurred following a cardiac arrest when there was a significant period before circulation was restored. The medical cause of death was 1a) Chest Infection on a background of hypoxic brain injury 1b) Cardiac arrest 1c) Ischaemic and hypertensive heart disease II) Urinary Tract Infection
4	CIRCUMSTANCES OF THE DEATH On 15th December 2017 Jack Goodwin was at an address in Timperley when he experienced chest pains. Contact was made with the ambulance service at 09:49. The call was categorized as a category 2 call, requiring an average response within 18 minutes and 9 out of 10 within 40 minutes. The call lasted 5 minutes and 19 seconds. Jack Goodwin deteriorated and a decision was taken to drive him to a hospital as it was believed the ambulance was likely to be delayed due to the level of busyness indicated by the call operator. At 10:01 the ambulance was cancelled and he was en-route to Altrincham Hospital. The hospital chosen did not have an A & E department and is not an acute hospital. At 10:07 a further call was made to NWAS indicating Jack Goodwin was still in the car but was now unconscious.

	At 10:10 the address (outside Altrincham Hospital) was verified and emergency services were dispatched at 10:12. They arrived at 10:20. That call was categorised at category 1. On arrival of NWAS a defibrillator was being used on Jack Goodwin. He was in ventricular fibrillation. At 10:44 there was a return of spontaneous circulation and he was transferred to Wythenshawe Hospital. Cardiac investigations found no clear cause of the cardiac arrest. He had sustained a significant hypoxic brain injury as a consequence of the prolonged downtime. He had significant cognitive impairment and as a consequence was at risk of aspiration pneumonia and chest infections. Catheterisation that was required as a consequence of his reduced cognitive function made him susceptible to urinary tract infections. He required significant assistance with daily living. In January 2020 he had deteriorated further and had on the balance of probabilities developed a chest infection. On 15th January 2020 he died at his home address [redacted], Cheadle, from complications arising from the cardiac arrest and prolonged downtime he suffered on 15th December 2017.
5	<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 as follows. – 1. The inquest heard that at the time of the calls to NWAS on 15th December 2017 they were very busy. The script used by the call handler allowed them to indicate that they were busy. However it did not allow for any suggestion or discussion about whether he would be better to make his own way there or allow for the provision by the call handler of a realistic timescale for the ambulance arriving. As a consequence it was difficult for the call maker to make an assessment of the best course of action to ensure that Mr Goodwin received medical attention at the earliest opportunity. 2. When a decision was made to take Mr Goodwin direct to the hospital and NWAS were told. There was no provision within the script to emphasise that the hospital would need to be an acute hospital with an A and E department. 3. There was an indication that given that if Mr Goodwin deteriorated then a further call should be made to NWAS. The evidence before the inquest was that this was not emphasised in such a way within the script to ensure that the call maker understood that this was

	key to ensure there could be a further assessment of urgency.
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 8th April 2021. 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 namely [redacted], wife of Mr Goodwin, 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	**Alison Mutch** **Senior Coroner, for the Coroner Area of Greater Manchester South**  **11/02/2021**