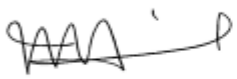
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Dr [redacted]** **c/o Priority Dispatch Corporation** **Suite 4b Spectrum** **Bond Street** **Bristol** **BS1 3LG**
1	**CORONER** I am Jacqueline DEVONISH, Area Coroner for the coroner area of Suffolk
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 08 June 2021 I commenced an investigation into the death of Colin Michael SWAIN aged 42. The investigation concluded at the end of the inquest on 04 March 2022. The conclusion of the inquest was that Mr Swain died from Hypoxic brain injury due to aspiration of the gastric contents following alcohol intoxication. It was not possible on the balance of probabilities to determine the point at which Mr Swain's brain was starved of oxygen such that he would stop breathing, and whether turning him from his side to his back for CPR commencement caused or contributed to his death.
4	**CIRCUMSTANCES OF THE DEATH** On 22 May 2021 Colin Swain, who had a history of alcohol excess, but did not drink in the presence of his family, was found collapsed in his front garden after going outside for a cigarette and a drink. The toxicology results indicated a level of alcohol associated with a coma. During the emergency call to the ambulance service the call handler was informed that he had been drunk, had fallen hitting his head and was unconscious. His breathing was assessed by the call handler and found to be agonal. The advice was to commence CPR for which he needed to be on his back. He was at that time on his side with his head down. Mr Swain vomited as he was turned, and advice was given to clear his mouth. Immediately upon turning him to his back Mr Swain stopped breathing. Bystander CPR followed until the ambulance service attended and achieved ROSC to transfer him to hospital. On admission the CT scan indicated hypoxia and he was presumed to have consumed enough alcohol to produce an obtunded state of consciousness with alcohol as the precipitant cause of death. Airway protected reflexes could fail in these circumstances, and in the absence of medical help, laryngospasm could be lethal. The clinical evidence was that he had aspirated his stomach contents which would itself have caused hypoxia worsened by a degree of laryngospasm closing the airway completely. The anoxic insult which can occur within 4 minutes lasted long enough to stop his heart. The paramedic attending the scene gave evidence that in agonal breathing the only course available to a bystander was to commence CPR pending arrival of an ambulance. For that to happen a patient had to be laid on their back.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) When a patient has been known to have been drinking alcohol, whether there is an algorithm in the MPDS detector which takes this into consideration. (2)If the MPDS does provide support for alcohol intoxication, whether this includes support in how to clear the mouth and nose to good effect. If it does not, whether this something which could be included in the Tool. (3 Whether turning an unconscious patient onto their back after vomiting is good practice, in the absence of clinician support
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 May 05, 2022. 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 [redacted] **Wife** [redacted] **Father** [redacted] **Mother** I have also sent it to [redacted] **Patient Experience Manager at the Ambulance Operations Centre** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 10/03/2022**  **Jacqueline DEVONISH** **Area Coroner for** **Suffolk**