Regulation 28: Prevention of Future Deaths report

César Cuauhtémoc GONZÁLEZ BARRÓN (died 11.05.19)

	THIS REPORT IS BEING SENT TO: 1. **Mr Marcus Davey** **Chief Executive** **Roundhouse** **Chalk Farm Road** **London** **NW1 8EH** 2. [redacted] **Managing Director** **First Aid Cover Limited** **19 Eltringham Street** **London** **SW18 1TD** 3. [redacted] **Event Producer** **White Branch Live Limited** **48a Bassein Park Road** **London** **W12 9RZ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST**

	On 15 May 2019, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of César Cuauhtémoc González Barrón, aged 51 years. The investigation concluded at the end of the inquest on 11 October 2019. I made a narrative determination at inquest, which I attach. The medical cause of death was: 1a acute heart failure 1b coronary artery atherosclerosis with recent thrombosis 2 hypertensive heart disease
4	**CIRCUMSTANCES OF THE DEATH** Mr González Barrón died whilst performing in the ring as a Mexican wrestler at the Roundhouse in Camden, at a Lucha Libre event promoted by Ruben Cordero with first aid provided by First Aid Cover Limited.
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. 1. When Mr González Barrón lost consciousness, there was a delay before it was recognised that this was not part of the performance. He was 51 years old and undergoing very vigorous exertion, but there was nobody at the wrestling match tasked specifically with ensuring that he was well and that, for example, he had not lost consciousness. 2. The first aider covering the Lucha Libre event had never worked at the Roundhouse before that day, but she did not seek and was not offered any sort of briefing by the Roundhouse staff either before she began her shift or at any time during it. She did not appreciate that there would be non native English (mostly Spanish) speakers working the event, which might raise language barriers in an emergency. She did not know who the staff were, how to identify them or where they would be positioned. She did not know the procedure for summoning assistance.

She did not know the protocol for ringing an ambulance. She did not know who should do this or how she could ensure that it was done. She did not know that the ambulance should be directed to the rear of the building.

3. In the event, the instructions given to the London Ambulance Service did not include the direction to drive round to the rear entrance and so valuable minutes were lost as the paramedics made their way from front to rear on foot outside the building.

4. When the first aider was summoned urgently, the member of staff who had alerted her said that she was needed for a performer, but did not tell her what had happened. She had no understanding of the nature of the emergency.

   The member of staff did not wait for her. He did not offer to help carry her equipment. She tried to follow him but did not know where she was going.

   The first aider did not take the defibrillator with her when she first went to the ring, she said in court because she was not expecting a cardiac arrest. There was a second defibrillator in the venue, but she did not know where it was, she did not ask for it and nobody brought it.

5. When the first aider arrived at Mr González Barrón's side, she cut off his face mask. Though she was told immediately by someone she thought to be a doctor that Mr González Barrón was not breathing and had no pulse, she did not start cardiopulmonary resuscitation (CPR).

   She did hand over her pocket mask and oropharyngeal airways, and she did go to retrieve emergency equipment from the first aid room 15-20 seconds away, but she could not remember in court if she fetched the defibrillator on her first or second return to the first aid room.

6. When Mr González Barrón collapsed, the scene was chaotic. No person took charge. There were lots of people in the ring, but the first aider was unable to identify which, if any, were staff, so that she could ask them for assistance, for example in retrieving her equipment. She was distracted by the noise and comment of those around.

7. The chest compressions in progress when the London Ambulance Service (LAS) arrived were ineffective.

8. The handover to LAS was confused, with mixed messages as to whether the automated external defibrillator had delivered a shock or not. No person took charge of a competent handover to LAS.

	All of this resulted in the following. César González Barrón could be seen to begin struggling at around 10.13pm, although this was not recognised at the time. He collapsed unconscious at 10.15pm. It is unclear at what time his breathing and heartbeat were first checked and it is not known exactly when he suffered a cardiac arrest. He was put in the recovery position at 10.17pm. This was two minutes after he lost consciousness. Either he should have been placed in the recovery position as soon as he lost consciousness and had been properly assessed, or if he had already arrested CPR should have been started immediately. Nearly four minutes after he had stopped moving, at 10.19pm, the first aider got into the ring, though the first aid room was only 15-20 seconds away. She was told that he had no breathing or heartbeat. A minute later, at 10.20pm, Mr González Barrón was turned onto his back and a 999 call was made to the London Ambulance Service. The call should have been made five minutes earlier, when he lost consciousness. Chest compressions were started two minutes after that, at 10.22pm. CPR should have been started as soon as Mr González Barrón arrested, which was at least two minutes earlier, possibly more. The London Ambulance Service arrived at his side and confirmed the cardiac arrest at 10.30pm.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 16 December 2019. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • the Health and Safety Executive • [redacted] London Ambulance Service • the family of César González Barrón. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** 14.10.19 **SIGNED BY SENIOR CORONER**