REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **JD WETHERSPOONS PLC** **WETHERSPOON HOUSE** **CENTRAL PARK** **REEDS CRES** **WATFORD** **WD24 4QL**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 the 11th August 2022 I commenced an investigation into the death of Christopher James Locke. The investigation concluded at the end of the inquest on the 24th of August 2023. The medical cause of death is 1a) hypoxic ischaemic encephalopathy 1b) cardiac arrest 1c) cardiac arrhythmia in a man with a fatty heart who had sustained a blow to the head The conclusion of the inquest as to how Mr Locke came to his death was a narrative conclusion and is as follows:- The deceased died from hypoxic ischaemic encephalopathy, caused by a cardiac arrest, which itself was caused by a cardiac arrhythmia in a man with a fatty heart and sustained a blow to the head. The emergency services did not instruct the caller to initiate chest compressions when given sufficient information to give that instruction, and this more than minimally contributed to the deceased's death
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Christopher James Locke and he was pronounced dead on the 29th October 2021 at Morriston Hospital, Swansea. The cause of death was hypoxic ischaemic encephalopathy, caused by a cardiac arrest, which itself was caused by a cardiac. Christopher was admitted to Morriston Hospital via UHW Hospital Cardiff on the 23rd

	October 2021 having sustained a cardiac arrest at the Lord Cradoc public house, Port Talbot during the evening of the 21st of October 2021. The cause of the cardiac arrest was found to be a cardiac arrhythmia. The staff at the Lord Cradoc called 999 and followed the instructions provided by the Emergency Medical Dispatcher (EMD). The EMD did not instruct the staff to undertake CPR. Christopher's circulation was restored 12 minutes after the arrival of the paramedics, who arrived 8 minutes after the commencement of the call. It was therefore estimated that Christopher had been without oxygen for at least 20 minutes. Christopher died from a brain injury caused by this lack of oxygen.
5	**CORONER'S CONCERNS** During the course of the inquest it transpired that there had previously been a scheme undertaken by Wetherspoons allowing staff to undertake additional training including CPR training. The evidence that was heard from a Consultant Intensivist was that the sooner that CPR can be commenced the greater chance that a person is able to survive a cardiac arrest, with minimal if no long lasting disabilities. The inquest concluded that the EMD should have directed staff at the Lord Cradoc to commence CPR and it is understood that compulsory training has been given to all Wetherspoons staff to enable them to comply with EMD instructions. This compulsory training dod not extend to CPR training. It is not the purpose of this report to compel your organisation to provide CPR training to its staff but to make such training available to staff who express an interest. It is recognised that such situations are stressful situations and that it would be unfair to impose compulsory CPR training to staff, however as with all organisations some individuals would welcome the opportunity to benefit from such training. No failings were found against the staff who attended to Christopher that evening and they ought to be commended for their actions. I am concerned that in such cases bar staff at pubs will invariably find themselves in situations where the administering of emergency CPR treatment ought to be administered. The time taken between the beginning of an emergency call and an instruction to commence CPR may deprive a patient of a favourable outcome. Whilst Wetherspoons staff have been trained to comply with EMD instructions there are occasions such as this case where staff could implement CPR of their own accord before being instructed to do so by EMD's. The training would not only teach staff the correct techniques but educate them of the situations in which CPR should be used. 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. In a pub environment there is a greater chance for the public to sustain injuries that requires emergency treatment 2. Ordinary bystanders' ability to administer emergency treatment may be hindered by their own consumption of alcohol 3. Whilst the primary responsibility of staff is to comply with EMD directions they are deprived of the opportunity to provide lifesaving treatment in circumstances that warrant it if that training is not offered 4. Staff would not know the circumstances that warrant it without the benefit of CPR training.
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 19 October 2023. 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] 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	**24 August 2023**  **[SIGNED BY CORONER]**