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RESPONSE OF CENTRAL ENGLAND CO-OPERATIVE LIMITED TO REGULATION 28 REPORT ISSUED BY H.M. AREA CORONER FOR NOTTINGHAM CITY AND NOTTINGHAMSHIRE

1. This is the response of Central England Co-operative Limited to the Regulation 28 Report issued by H.M. Area Coroner for Nottingham City and Nottinghamshire following the Inquest touching upon the death of Mackenzie Cooper, dated 13th July 2023, but received on 21st August 2023, and requiring a response by 16th October 2023.

2. At the outset we take the opportunity to express our sincere condolences to the family and friends of Mr Cooper. We acknowledge the deep upset and sadness his tragic death at such a young age will have caused.

3. H.M. Area Coroner has raised two matters of concern for consideration. We set them out below for ease of reference:

   3.1 The community public access defibrillator in your store was supplied to a member of the public in a non-workable condition. There appears to be either no system for replacing the pads between uses, or an unsafe system in operation; and

   3.2 There appears to be either a training or communication issue in that staff appear to have known the device was missing vital equipment, but the device was supplied anyway.

4. We will in this response deal with the matters of concern in the following way:

   4.1 We will make our introductory comments and observations;

   4.2 We will set out the system in place at the time;

   4.3 We will address why it was that the defibrillator remained available for use in circumstances where it appears it shouldn't have been, due to missing pads;

   4.4 We will set out what has been reviewed as a result of H.M. Area Coroner's Regulation 28 Report and what actions have been taken as a result or are planned to be taken; and the timescales in which such actions have been taken or will be taken.

Introductory Comments

5. Central England Co-operative Limited has for several years, as part of its positive contribution to the communities it is privileged to operate in, and in accordance with its values, partnered with a charity, The British Heart Foundation, and with local NHS Trust Ambulance Services, in providing community defibrillators outside many of its retail premises.

6. Central England Co-operative Limited offers a freely accessible 24 hour a day, seven day a week service with its defibrillators and has chosen not to restrict access, unlike some models of defibrillator provision in use by other businesses and institutions.

7. As at mid-September 2023 it has 282 defibrillators outside its retail premises. In the approximate five years it has been providing defibrillators in this way it has not encountered any issues of the kind highlighted by H.M. Area Coroner in the Regulation 28 Report.

8. In responding Central England Co-operative Limited acknowledges that it was the operator of the Co-op store at Carlton in Lindrick, Nottinghamshire and, as H.M. Area Coroner puts it, it was therefore the "guardian" of the defibrillator referred to in the Regulation 28 Report.

9. Central England Co-operative Limited did not attend or participate in the Inquest touching upon the death of Mr Cooper and did not therefore have the benefit of listening to the evidence which H.M. Area Coroner has heard and has summarised in the Regulation 28 Report. It responds taking the summary provided as accurate, and it accepts for the purposes of this response that the defibrillator in question was effectively made available for use when the pads necessary for its proper function were absent.

10. Central England Co-operative Limited did at the time have in place a system, developed with those with whom it works as regards defibrillators, including The British Heart Foundation, which, if properly operated, should have prevented the circumstances outlined in the Regulation 28 Report from arising.

11. At all times it has been understood by Central England Co-operative Limited that the recommendations of The British Heart Foundation as to that system represented commonly adopted best practice.

12. That system, if operated properly at the time of events, should have resulted in the defibrillator at the Carlton in Lindrick store being marked on the system known as “the circuit” (to which the emergency services have access to check status of defibrillators) as (effectively) “out of service”, pending replacement of the pads.

13. Having conducted an investigation as a result of the concerning matters reported to it by H.M. Area Coroner in the Regulation 28 Report it has been established that the immediate cause of the defibrillator being left “in service” whilst it was missing the pads necessary for its use was human oversight on the part of a member of staff at the Carlton in Lindrick store.

14. The member of staff accessing the system as part of a check conducted in advance of the tragic events involving Mr Cooper failed to mark the defibrillator as “out of service” on “the circuit”, as they should have done, and as the system provided for.

15. The investigation has though taken the opportunity to look at matters more broadly and what is set out below by way of actions and planned actions results from that broader review.

The System in place at the time

16. Central England Co-operative Limited has adopted a system for maintaining and denoting the accurate status of defibrillators based on the guidance issued by The British Heart Foundation, and in partnership with them.

17. The system involves:

    17.1 Written instructions to stores with defibrillators from the British Heart Foundation relating to registering the defibrillator on “the Circuit”;

    17.2 Stores with defibrillators have received short awareness sessions from Kays Medical, who are a distributor for medical products and service, on when and how to use a defibrillator, how to access the defibrillator cabinet, and the checks that stores will undertake when the store has a defibrillator fitted. Residents and local businesses are invited to and participate in these awareness sessions. The store will not be able to access “the circuit” until the awareness session has been conducted. Stores can request refresher awareness sessions;

    17.3 Although not mandated there is additional training and awareness available for all staff of Central England Co-operative Limited. A learning course entitled ‘Defibrillators – Know the Facts’ is hosted via the “Let’s Learn” online learning portal. This consists of three modules, a) Defibrillator Overview (video), b) How to use a defibrillator (video) and c) Defibrillators – know the facts (a two-page pdf fact sheet). Internal training is not a requirement stipulated by The British Heart Foundation but is something which Central England Co-operative Limited has created for its own purposes;

17.4 The details and log-ins provided in written instructions to Store Managers and Duty Managers allow the store to access “the circuit” and confirm the status of a defibrillator as available for use or not available for use;

17.5 The status may need changing to inactive/not available for use for a variety of reasons: for example, (a) taken/used; (b) otherwise missing; (c) vandalised; or (d) missing or out of date parts (consumables). Examples of parts/consumables are: heavy duty scissors, towelette for drying away moisture to ensure the pads adhere, a safety razor, a face shield;

17.6 A monthly programmed check by the store on the defibrillators, prompted by written reminders each month, is conducted. This is conducted as an exercise as part of Central England Co-operative Limited’s legal compliance monitoring checks. The monthly interval for the check, and the checks themselves, are in accordance with The British Heart Foundation Guidelines;

17.7 The defibrillator check covers: (a) whether the defibrillator is missing (and provides for a check with the relevant ambulance service to see whether the unit has been used but not returned. If the defibrillator is not returned within 14 days (post-event) then a replacement is ordered); (b) the defibrillator cabinet is vandalised, damaged, faulty or difficult to shut; or (c) parts/consumables required.

17.8 In the event that the defibrillator check identifies an issue which would prevent its use/availability then the instructions are clear that it should be denoted on “the circuit” as inactive/not available. This is something which the person at the store conducting the check should attend to immediately using the online system available for such purposes;

17.9 The system provides for missing parts/consumables to be ordered from and delivered by Lyreco. Again this is something the store attend to using a portal to order new parts/consumables;

17.10 That the checks have been conducted by the stores is recorded on Central England Co-operative Limited’s Legal Compliance monitoring portal called ARCC;

17.11 In addition, Legal Compliance 2nd line team (i.e. independent of the store) auditors visit each store on a periodic basis, usually annually (occasionally more frequently), to undertake a full legal compliance audit. As part of this, auditors check that defibrillator checks have been completed by the store every month and recorded on ARCC;

17.12 The Legal Compliance 2nd line team also monitor the completion of all programmed monthly checks by stores (that is all legal compliance checks, not just those which relate to defibrillators). Where any store appears to have completed fewer than 90% of the expected checks this is flagged to the store management teams and operational management and area management teams for action and improvement.

Had the system been properly operated at the relevant time it was capable of avoiding the situation about which H.M. Area Coroner has understandably raised concerns.

Why the Defibrillator was denoted as available for use on “the circuit”

18. Following receipt of H.M. Area Coroner’s Regulation 28 Report Central England Co-operative Limited has conducted certain investigations as a result of its deep concern at the matters raised.

19. It appears that the status of the defibrillator was not properly updated after it had been used shortly before the events involving Mr Cooper, due to human oversight.

20. A monthly defibrillator check was conducted at the Carlton in Lindrick store on 24th September 2022, just a few days before the incident involving Mr Cooper.

21. The member of staff completing the check responded to the questions set out on the check as follows:

    21.1 Is the defibrillator in the correct location? “Yes”

    21.2 Are there two sets of in-date pads and an unopened starter kit in the cabinet? “No defib used this week awaiting new pads”

    21.3 Is the battery indicator complete? “Yes”

    21.4 Has the defibrillator check been recorded on ‘The Circuit’? “Yes”

    21.5 Enter below name of person completing this check. [please note that the member of staff did identify themselves, but their name has been redacted in this Response to the Regulation 28 Report in the interests of fairness to the individual concerned]

22. When questioned about matters the member of staff stated “*We didn’t sign it off in the circuit and it was an oversight on our part, we thought it had been completed”.*

23. Accordingly, it is clear that the member of staff knew what was required and acknowledged their error in failing to do what was required.

24. It is understood that the defibrillator had been taken from its cabinet for the purposes of dealing with another incident during the week before the tragic incident involving Mr Cooper. It is also understood that the store was not immediately aware that it had been taken away to be used at the time.

25. Had the defibrillator been confirmed as not available for use on “the circuit”, as it should have been, then the emergency services would not have sent the member of the public to the Carlton in Lindrick store. The emergency services, when accessing “the circuit” would, in those circumstances, have seen the defibrillator denoted as being not available for use.

26. Where it was confirmed by the check that the defibrillator was missing the required in-date pads, the unit should have been removed from service on “the circuit” to ensure the Ambulance Service did not send anyone to it in the event of an emergency. Regrettably the defibrillator status was not updated to unavailable on “the circuit” and therefore it remained ostensibly available for use.

27. On the day of the incident involving Mr Cooper the device was taken offline by the store (and therefore showing as unavailable on “the circuit”) when the defibrillator was not returned and the store contacted the Police to try and establish its whereabouts. In addition, East Midlands Emergency Services also contacted the store to confirm they were taking the device off “the circuit”.

28. Once the replacement pads had been received, the defibrillator was put back online on “the circuit” in November 2022. The British Heart Foundation have confirmed that the defibrillator was offline between 29th September 2022 and 30th November 2022.

Review of System and Actions taken/planned

29. In light of its concerns at the matters reported by H.M. Area Coroner Central England Co-operative Limited has reviewed its systems generally as regards defibrillators.

30. A concern identified as a result of that review is that the interval between checks on the defibrillator of one month, notwithstanding that this was the recommendation of The British Heart Foundation and understood to represent best practice, appears to leave potential, in certain limited circumstances (see below), a window when the defibrillator may have been used without the store staff or the ambulance service being aware and therefore able to take it offline from “the circuit” promptly. This may result in “the circuit” showing an inaccurate available for use status for a defibrillator.

31. To explain, it is possible, and does occasionally happen, that stores can be unaware when a defibrillator has been used or taken. The stores are open for a limited number of hours a day. The defibrillators, so that they can be accessed at any time (in accordance with Central England Co-operative Limited's values that these are a general community asset) are outside the stores, not inside them. Therefore, a defibrillator can be used (or taken) and not returned or used and/or some parts/consumables be used, outside store hours and without the store staff being aware. Likewise, defibrillators can be subject to vandalism and other abuse about which the store staff may not always know immediately.

32. If such use was by or at the behest of the ambulance service, then no issue would arise as they can access "the circuit" and they would denote the defibrillator as not available for use.

33. Normally a member of the public needing to use the defibrillator would have to call the emergency services to obtain the code to open the cabinet. But it is understood that codes, which can be common codes in certain ambulance areas, can be known by certain members of the public. Therefore, it is possible that, as well as vandalism/abuse, that there could be a circumstance where a defibrillator was used where neither the ambulance service nor the store were aware and did not have the opportunity to update the status of the defibrillator on "the circuit".

34. As a result, and after careful consideration, Central England Co-operative Limited has increased the frequency at which checks are conducted on the defibrillators. The decision made is that checks shall now be undertaken at one-week intervals. This system change will commence on 1st November 2023.

35. As an additional safeguard from September 2023 the Central England Co-operative Limited Facilities Management team now monitor "the circuit" on a weekly basis and generate a report to provide information on the status of all 282 defibrillators to store managers, operational managers, and senior operational managers.

36. The managers are then required to follow up with individual stores where any exceptions are highlighted to ensure the required mitigating actions have been/are executed or, if necessary, intervention can take place.

37. The information provided to managers includes details of (a) sites with defibrillators that are online/emergency ready, and those that are offline/not emergency ready (the question being asked "is the status denoted accurate?"); (b) date of "last service" of each defibrillator. This is the last date that the defibrillator was checked by the site; and (c) pad/battery expiry date. This displays all defibrillators where the pads/batteries are approaching or have exceeded their expiry date and need replacement.

38. Central England Co-operative Limited has also reviewed its provision of training and awareness to ensure that training/awareness both mandatory and held at intervals which will ensure new starters are captured promptly. In addition, the training content has been reviewed. From 1st November 2023 updated training is being launched which is mandated for all store staff and store managers (including duty managers), which includes a module on maintenance and correctly denoting defibrillators as available for use or not available for use. New starters post 1st November 2023 will be required to complete this training within four weeks of the commencement of their employment, effectively as part of their induction.

39. Finally, and importantly, Central England Co-operative Limited will initiate a discussion with The British Heart Foundation as a result of the concerns identified by H.M. Area Coroner and its own careful consideration of matters. Such discussions will be initiated prior to 1st November 2023. At this stage it is not possible to place a timescale on when such discussions will conclude, but the intention on the part of Central England Co-operative Limited is that the discussions should take place promptly. Central England Co-operative Limited believes that this step has potential for strengthening controls generally and therefore having a positive impact more widely.

Summary

40. We hope that what is set out above is of assistance to H.M. Area Coroner.

41. Dealing with the specific concerns raised by H.M. Area Coroner we summarise (we hope helpfully) as follows:

    41.1 The community public access defibrillator in your store was supplied to a member of the public in a non-workable condition. There appears to be either no system for replacing the pads between uses, or an unsafe system in operation; and

    41.2 There appears to be either a training or communication issue in that staff appear to have known the device was missing vital equipment, but the device was supplied anyway.

42. It is accepted that the defibrillator was effectively made available for use when it was not in a workable condition. Clearly this is much regretted. It is accepted that the defibrillator should have been denoted as not being available for use. It is hoped that for the reasons explained above H.M. Area Coroner will see that there was (and is) a system in place for replacing the pads and for notifying “the circuit” that a defibrillator is not available for use. The system was not therefore unsafe in itself. The issue was primarily one of human oversight, and the system was not, on this occasion, operated satisfactorily.

43. The store management were aware of the requirements to denote the defibrillator as not available for use but failed properly to update “the circuit” to reflect that so that the emergency services were aware.

44. As referred to above a review has been conducted and certain improvements have been or are shortly to be made to the system operated by Central England Co-operative Limited, and further discussions with The British Heart Foundation will take place in due course in the interests of a wider positive impact. Central England Co-operative Limited is committed to offering public access defibrillators in the communities in which it operates 24 hours a day seven days a week and is committed to ensure that it, and others offering defibrillators, does so in a way which will ensure prevention of any recurrence.

Signed:

For and on behalf of Central England Co-operative Society

Dated: 13 October 2023