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 Central England Co-operative (Food)** **2 The Department for Health and Social Care**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City and Nottinghamshire
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 17 October 2022 I commenced an investigation into the death of Mackenzie COOPER, aged 27. The investigation concluded at the end of the inquest which took place before a jury on 12 July 2023. The conclusion of the jury was that: Mackenzie Cooper died on 29 September 2022 at a private residential dwelling in [redacted], Nottinghamshire, as a result of cardiac arrhythmia induced by electrocution. Mackenzie was a Plumber, qualified to NVQ level 2 and 3 in Domestic Plumbing and Heating, and Gas Safe Registered, with 5 years' experience working independently. He was called out to a residential property to deal with an emergency leak, and he attended alone. The electricity was turned off before Mackenzie arrived. The power was turned on to enable Mackenzie to vacuum up water. He was electrocuted when kneeling in water, he touched or came into close proximity to a copper pipe that was inadvertently carrying a live electrical current when the power was switched on. This was due to a combination of two faults in the house electrical system: 1. The earth terminal in the fuse box was not connected to general mass of earth; 2. Faults or inadvertent connection between live and earth in the main socket circuit. Both of these faults in combination caused the pipe to carry a live electrical current, once the power was switched on. The occupier called 999, and commenced CPR, continuing until ambulance crews arrived. The homeowner fetched a community public access defibrillator, which was not functional due to missing pads. An ambulance arrived after 20 minutes, a short delay resulting from resource availability, but there was no evidence these factors contributed to his death as he was already asystole when ambulance crews arrived. Mackenzie was pronounced deceased at the scene at 15.43.

4	**CIRCUMSTANCES OF THE DEATH (relevant to this report)** The occupier of the private dwelling gave evidence that he and his wife were advised by the East Midlands Ambulance Service NHS Trust, during the course of the 999 call, to fetch a nearby community public access defibrillator from the Co-op store, 29 Doncaster Road, Carlton-in-Lindrick, Worksop, Nottinghamshire, S81 9JX. The device was provided to the occupier by co-op staff. When the occupier arrived at Mackenzie's side and opened the defibrillator pack, the audible instructions advised that the pads should be connected to the leads. On exploring the entirety of the device pack, it became apparent there were no pads, meaning the device could not be used. This delayed the use of a defibrillator, and the administration of a shock, if Mackenzie was in a shockable rhythm. When the occupier later returned the device to the Co-op store, staff informed them that they knew the device was missing the pads because they had not been replaced since the device was last used. I received evidence from East Midlands Ambulance Service NHS Trust that responsibility for maintaining the defibrillator device and associated equipment, including replacement pads, rests with the "guardian" of the device, not with the with the ambulance service. The ambulance service simply has access to a list of the locations of community pubic access defibrillators and advise callers of their nearest device in a cardiac arrest scenario. I understand there were other community access defibrillators very close by which the occupier could have accessed if the ambulance service had known the device in the co-op store was "offline". I understand there is no single database listing the location and status of community public access defibrillators, rather a number of charity organisations provide such a service (NDDb and the British Heart Foundation) and I am unclear how the ambulance service are to know when a listed device is non-functional.
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: (brief summary of matters of concern) Central England Co-operative 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. 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. The Department for Health and Social Care 3. In December 2022, the Government committed to making available over £1 million for the purchase of more community public access defibrillators, in recognition of the fact that these devices have the potential to save lives. I am concerned that without a clear system for ensuring (a) the maintenance and good order of all community public access defibrillators, and (b) a system for sharing with all ambulance Trusts the current status of defibrillators i.e. when they are out of service due to missing parts/maintenance, members of the public might be directed to a device that cannot be used, as in this case.

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 October 16, 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; Mackenzie's family His employer The homeowner and occupier who collected the device in question I have also sent it to The National Defibrillator Database (NDDb) The British Heart Foundation, The Circuit 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: 13 July 2023** **Miss Laurinda Bower** **HM Area Coroner** **For Nottingham City and Nottinghamshire**