REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch , senior coroner, for the coroner area of Manchester South
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 8th November 2024 I commenced an investigation into the death of **Jake Samuel Lawler**. The investigation concluded at the end of the inquest on 15th April 2025. The conclusion of the inquest was narrative: Died from a biventricular arrhythmogenic cardiomyopathy when he was incorrectly diagnosed in life with exercise induced asthma and the significance of a witnessed exercise induced syncope episode, and an abnormal ECG were not recognised or actioned appropriately. The medical cause of death was **1a) Biventricular arrhythmogenic cardiomyopathy**
4	CIRCUMSTANCES OF THE DEATH Jake Samuel Lawler was diagnosed by his GP practice with exercise induced asthma and prescribed treatments that did not have any significant impact on his symptoms. On 13th October 2024 Jake collapsed while playing football and had a short period of unconsciousness. He was taken to Wythenshawe Hospital by his

	father. A full history was given that was consistent with an exercise induced syncope. An ECG was carried out. That was abnormal and showed a T wave inversion on lead V5. The clinicians noted there was the T wave inversion but did not recognise that this was a concerning finding from the ECG. The history given by his father was not assessed correctly. The T wave inversion particularly in combination with his collapse should have resulted in him being referred for an inpatient paediatric review and further testing. It is probable that he would not have died on the day he did had the correct actions been taken. Jake's collapse was incorrectly attributed to his exercise induced asthma. He was referred back to the GP for review. He was reviewed by a GP by telephone on 14th October and face to face on 18th October 2024. A FeNO test referral to the asthma nurse was made. On 31st October 2024 the FeNO test was conducted. The asthma nurse referred Jake back to the doctor indicating they did not believe Jake had asthma. There was a plan to refer him to paediatrics. It was clear that the diagnosis of exercise induced asthma being the cause of his collapse on the 13th October 2024 was unlikely and that the working diagnosis within the discharge summary was probably incorrect. The significance of that was impacted by the discharge summary incorrectly describing the ECG as normal. On 5th November 2024 whilst playing football Jake collapsed. Attempts to resuscitate him were unsuccessful and he died at Wythenshawe Hospital on 5th November 2024. The postmortem carried out found he had died as a consequence of having Biventricular arrhythmogenic cardiomyopathy
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence 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. The inquest heard evidence that the significance of 12 lead ECG readings are regularly missed or misunderstood by clinicians which means that key warning signs are missed as in

	Jake's case. It is unclear if this is a training issue or the way in which the machines report or volume. Without an improvement there will be further avoidable deaths 2. Jake presented with a clear paediatric exercise induced syncope. The inquest was told that there is no clear national guidance on the pathway to be followed in relation to such children although medical training emphasised that this should be treated as a red flag event. 3. The diagnosis of exercise induced asthma appeared to be based on a history given at the early stages of his breathlessness being reported to the GP and was not revisited even when he was reporting that the classic treatments were not having a significant impact on his symptoms. This was compounded by the exercise induced syncope being incorrectly linked to asthma. In addition, Jake was assessed by his GP practice using the national asthma scoring system. However, the scoring system does not appear to facilitate scoring for exercise induced asthma. In Jake's case the readings and answers pointed to a well-controlled asthma. This was at variance with the fact that his history indicated that he was continuing to struggle with his breathing when exercising and meant he did not trigger as a concern. This was exacerbated by the normal peak flow readings taken at rest which gave a falsely reassuring picture. A lack of curiosity, a lack of appreciation of the limitations of the national scoring system and a non-holistic approach meant that he continued to be seen as asthmatic when all his symptoms were as a result of his undiagnosed Biventricular arrhythmogenic cardiomyopathy 4. ECGs to rule out a possible cardiac issue cannot easily be given to children in a community setting.
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 **4th July 2025**. 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: Mother and Father of Master Lawler on behalf of the family, Manchester University NHS Foundation Trust, GP Surgery who may find it useful or of interest. 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. They may send a copy of this report to any person who they believe 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	**Alison Mutch** **HM Senior Coroner**  **09/05/2025**