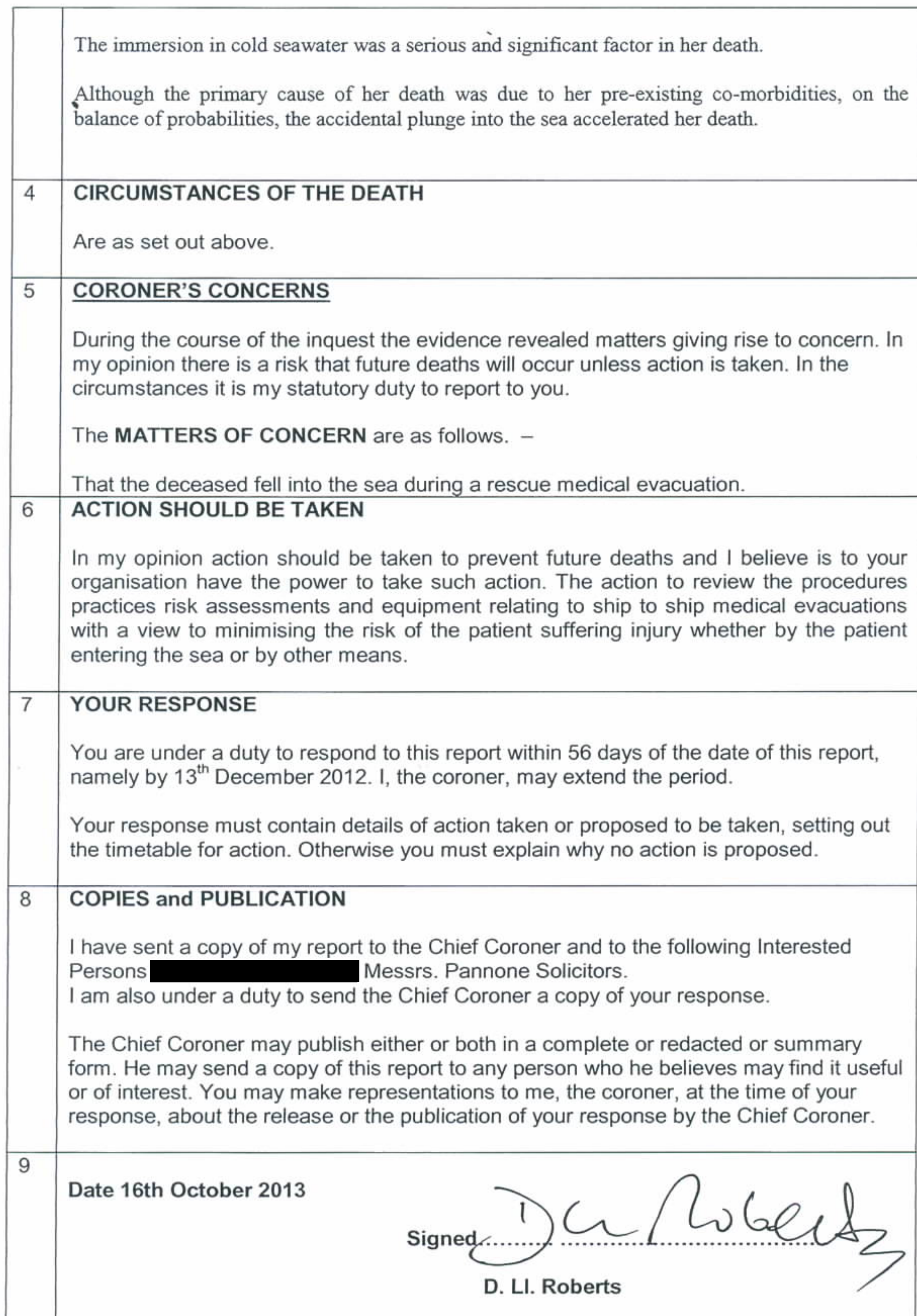
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **RE: JANET RICHARDSON Deceased** **THIS REPORT IS BEING SENT TO:** 1. **Redningsselskapet, PB 103, 1325 Lysaker, Norway** 2. **Cruise & Maritime Services International Limited, 4th Floor, 5-7 John Princes Street, London. W1G 0JN.** 3. **Newmarket Promotions Limited, McMillan House, Cheam Common Road, Worcester Park, Surrey. KT4 8RQ.**
1	**CORONER** I am David Llewelyn Roberts, Senior Coroner for North & West Cumbria.
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 28th April 2011 I commenced an investigation into the death of Janet Richardson – DOB – 10/08/1938. The investigation concluded at the end of the inquest on 15th October 2013. The conclusion of the inquest was On the 29th March 2011 whilst on holiday aboard a cruise ship in Norwegian waters the deceased became seriously unwell. It was necessary to get her ashore for Hospital treatment. It was decided that she be transferred ship to ship on to the aft of the rescue boat whilst strapped to a stretcher. In the process of transferring the stretcher the rescue boat moved away from the side of the cruise ship. Those on the rescue boat holding one end of the stretcher were no longer able to maintain their grip. Those on the cruise ship retained their grip slightly longer. The stretcher swung back against the side of the cruise ship into a vertical position and then it and the deceased fell into the sea. The deceased came free of the stretcher. She was pulled from the sea some minutes later and transferred to a Hospital on the Norwegian mainland. During the transfer the deceased was not wearing a life jacket or buoyancy aid. The stretcher was not attached to any line or rope. The two vessels were not tied together. After medical treatment in Norway the deceased was transferred to the Cumberland Infirmary, Carlisle on the 13th April 2011 where after further medical treatment she died on the 21st April 2011. The deceased had a medical history of Chronic Renal Failure, Diabetes and high blood pressure. She had had two recent Hospital admissions in the previous December and January. She died as a consequence of her pre-existing chronic medical condition; the cirrhosis of the liver being well established.



	The immersion in cold seawater was a serious and significant factor in her death. Although the primary cause of her death was due to her pre-existing co-morbidities, on the balance of probabilities, the accidental plunge into the sea accelerated her death.
4	**CIRCUMSTANCES OF THE DEATH** Are as set out above.
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. – That the deceased fell into the sea during a rescue medical evacuation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe is to your organisation have the power to take such action. The action to review the procedures practices risk assessments and equipment relating to ship to ship medical evacuations with a view to minimising the risk of the patient suffering injury whether by the patient entering the sea or by other means.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th December 2012. 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 Messrs. Pannone Solicitors. 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	**Date 16th October 2013** **Signed**.. **D. Ll. Roberts**