In the South London Coroners Court

Inquest touching the death of John Lobo

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **Exora Medical Limited, Unit 9 Balmoral Storage, Clive Way, Watford WD24 4PX**
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South London
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. http://www.legislation.gov.uk/ukpga/2009/25/contents
3	**INVESTIGATION and INQUEST** On 9th July 2014 I commenced an investigation into the death of John Lobo, aged 77 years. The investigation concluded at the end of the inquest on 21st April 2015. The conclusion of the inquest was that his death was accidental. The medical cause of death was 1a Bilateral bronchopneumonia 1b chronic obstructive airways disease Part II Ischaemic heart disease; cervical spine fracture and diabetes mellitus.
4	**CIRCUMSTANCES OF THE DEATH** On 15th May 2014 Mr Lobo suffered a fall in his bathroom on the cruise ship Ventura, close to the Italian coast. He suffered two further falls on the 19th and 21st May 2014 which may have exacerbated the injury. He was then admitted to a hospital in Venice and was subsequently transferred to the United Kingdom in a private ambulance. He was transported by road and his neck was not immobilised at all times during the journey. A dispute with the insurance company meant that the family had to make a private arrangement for repatriation, and although the ambulance company were made aware that Mr Lobo had suffered a fracture at C7 they wrongly recorded that the fracture was at T7. The ambulance crew (which included a paramedic) were informed by the Italian hospital that he was fit to travel and should be immobilised at times of transfer only. There was no indication that the fracture was in fact unstable, which may have been as a result of language difficulties. Translation services were available but not used. The evidence disclosed that transport by road was not appropriate, and that Mr Lobo should have been immobilised at all times, and these failures contributed to the cause of death.
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. – The evidence disclosed that assessment of fitness to travel and of the manner in which the patient should be transported requires medical knowledge over and above that of a paramedic, and that reliance should not be placed wholly on family members and hospitals in distant countries. In cases involving direct repatriation without the facilities provided by an insurance company, consideration might be given to obtaining independent medical assessment.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 6th July 2015** 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. (You have already filed a statement to assist this process, but should nevertheless respond fully, whether by re-submitting the statement or otherwise.)
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The family of Mr Lobo [redacted] (Ventura) I have also sent it to the [redacted] Prior and to the Care Quality Commission 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. 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	11th May 2015. Shuna Lynch **DATE** **SIGNED BY CORONER**