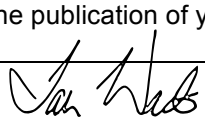
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **, Director,** Handicare Accessibility Ltd., 82 First Avenue, Pensnett Estate, Kingswinford, West Midlands, DY6 7FJ **2.** [redacted] **Director-General,** British Healthcare Trades Association, New Loom House, Suite 4.06, 101 Back Church Lane, London E1 1LU
1	**CORONER** I am Ian Wade QC, assistant coroner, for the coroner area of London East
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 31st October 2013 I commenced an investigation into the death of Joseph Allison, 84, born 10th October 1928. The investigation concluded at the end of the inquest on 11th March 2015. The conclusion of the inquest was that Mr Allison died from 1a. Bronchopneumonia; 1b. Fracture dislocation of cervical vertebrae; 2. Chronic bronchitis and emphysema, and a narrative conclusion was returned as follows: "Mr. Joseph Allison had a mechanical stairlift known as a Minivator 2000 installed in his home. It was serviced annually. It contained components which were subjected to stress forces during the course of usage and which were at risk of physical failure due to a design fault. These components had been the object of a manufacturer's upgrade programme between 2004 and 2006 but which had not been applied to this stairlift. These stairlifts were in addition the specific object of engineering bulletins but these were not applied to this stairlift. On the 18th October 2013 the upper trunnion assembly broke up while Mr Allison was operating the lift at the top of the staircase and he was precipitated down the stairs causing inter alia a fracture in the cervical vertebrae and a trauma injury to the head leading to intracerebral bleeding. These injuries substantially compromised his ability to resist the impact of respiratory infection leading to Bronchopneumonia from which he died on 27th October 2013".
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Allison was thrown from a stairlift in his home when components in the upper trunnion assembly failed. (2) The components were manufactured from inadequate materials and it was also acknowledged by the manufacturer in 2004 to be a faulty design. The manufacturer's upgrade programme was not properly or sufficiently carried out with the result that Mr Allison's stairlift was not given the retro-fitted parts which would have avoided this incident. (3) Moreover the manufacturer's internal record of compliance progress was

	completed so as falsely to show that the necessary work had been carried out. (4) In addition an engineering bulletin known as Bulletin 55 was issued to give guidance to fitters on the work required to upgrade this stairlift, and a subsequent Bulletin 66 was issued to instruct fitters on how to check a stairlift in situ in order to assess whether the critical component was in a safe condition, but service engineers were not given training, equipment nor specific reminders/alerts to investigate such stairlifts during routine maintenance visits. (5) Furthermore no information regarding this defect and the necessary remedial actions was released to appropriate third parties such as independent stairlift installers or dealers. (6) A total of 21 Minivator 2000 stairlifts have suffered the relevant component failure since this lift was first manufactured, 11 of which have occurred since the purported upgrade programme was terminated. 16 stairlifts were discovered to have been falsely recorded as upgraded following a recent audit, although these have since been correctly improved. However the manufacturer admits that 567 units have not been tracked down and rectified, and efforts to locate them have so far failed. (7) The further circumstances in the instant case are illustrated in the terms of the narrative conclusion.
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. – (1) In-house service engineers have not been specifically trained to be aware of the defect in the Minivator 2000, nor issued with feeler gauges to implement the appropriate safety check (2) In-house and third party service engineers are thereby exposed to the same risks which end-users face if they test-ride the serviced stairlifts themselves (3) No nationally publicised safety recall campaign has been undertaken to alert end-users to the danger, or request that such users contact the manufacturer for access to the remedial programme (4) No or no adequate initiative has been taken to advise the stairlift industry generally of the risks inherent in unimproved Minivator 2000 stairlifts
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 18th May 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted]. 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	**Monday 23rd March 2015**  **[SIGNED BY CORONER]**