REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **East of England Ambulance Service** **Whiting Way** **Melbourn** **Cambridgeshire** **SG8 6EN**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK
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 27 September 2018, I commenced an investigation into the death of ROBERT CHARLES CHANDLER, AGED 85. The investigation concluded at the end of the inquest on 20 FEBRUARY 2019. The conclusion of the inquest was medical cause of death: 1a) Respiratory Failure b) Traumatic Pneumothorax 2. Chronic Obstructive Pulmonary Disease, Dementia, Ischaemic Heart Disease, Frailty and a Narrative Conclusion: On 24 September 2018, Mr Chandler collapsed and suffered a pneumothorax. An ambulance arrived fifty minutes after the first telephone call was received and Mr Chandler was taken to the James Paget University Hospital where he died on 25 September 2018 from his injury.
4	**CIRCUMSTANCES OF THE DEATH** On 24 September 2018, Mr Chandler collapsed and suffered a pneumothorax. An ambulance arrived fifty minutes after the first telephone call was received and Mr Chandler was taken to the James Paget University Hospital where he died on 25 September 2018 from his injury.
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) The Mangar Elk inflatable chair was intended to be used to lift Mr Chandler to the ambulance. One section did not inflate and so Mr Chandler was lifted underneath his arms and transferred to a chair borrowed from a local supermarket, no pain relief was given to Mr Chandler before being placed into the ambulance. He was later diagnosed with a pneumothorax. No safety straps were used. (2) Staff are required to ask for assistance when required and are responsible for checking equipment daily. The evidence is that this is not always done. (3) An electronic tablet was used initially to record the incident but this was not sufficiently charged to record all information. Paper records were not adequately completed.

	(4) The incident occurred in September 2018 and the internal investigation report with recommendations was completed in January 2019. Recommendations within the Report and in particular a clinical debrief had not taken place at the time of inquest (February 2019)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 18 April 2019, 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](wife) son) 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	**21 February 2019** ..... **Jacqueline Lake** **Senior Coroner** **Norfolk Coroner Service** **Carrow House, 301 King Street** **Norwich, NR1 2TN**