for The Area of York

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The General Chiropractic Council
1	**CORONER** I am the Acting Senior Coroner for The Area of York
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/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12/09/2017 I commenced an investigation into the death of John Thomas Lawler, 80. The investigation concluded at the end of the inquest on 18 November 2019. The conclusion of the inquest was that on 11 August 2017 John Thomas Lawler suffered a fractured neck and spinal cord damage whilst undergoing chiropractic spinal adjustment and subsequent mobilisation. The spinal cord damage led to respiratory depression from which he died at 20:00 hours on 12 August 2017.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lawler sought chiropractic treatment as he was suffering with an ache in his legs. On 11 August 2017 whist undergoing a spinal adjustment using a drop table he stated that he could not feel his arms. He was then moved from the prone position on the treatment table to being upright on a chair next to the table. He became less responsive, an ambulance was called and paramedics transported Mr Lawler down the stairs in a carry chair on stair tracks. He was fully immobilised on the ambulance. A CT scan at York District Hospital confirmed he had ankylosis of the cervical spine, a fracture at C4/C5 and dislocation of the facet joints at C4/C5. There was significant narrowing of the spinal canal. Mr Lawler was transferred to Leeds General Infirmary where he underwent an MRI scan on 12 August 2017 which confirmed significant spinal cord compression. Mr Lawler's condition deteriorated and he died at 20.00 hrs that day. A post mortem examination confirmed the immediate cause of death as respiratory depression due to traumatic spinal cord injury and longitudinal ligament ossification with prominent vertebral body posterior osteophyte of C4/C5.
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) No pre-treatment images were taken of Mr Lawler's spine. Ossification of the spine was not known until post-trauma CT images were obtained. (2) A review of the requirement for pre-treatment imaging may inform whether a patient is suitable for treatment. (3) Mr Lawler was mobilised from the treatment table to a chair after loss of sensation in his arms. (4) Consideration should be given to making First Aid training mandatory for chiropractors

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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 13 January 2020. 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: Stewarts Solicitors, DAC Beachcroft, General Chiropractic Council and Yorkshire Ambulance Service. 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	Dated 26 November 2019 Signature: Jon Heath, Coroner for The Area of York

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