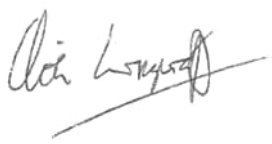
ANNEX A

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 **THIS REPORT IS BEING SENT TO:** **1. Schindler Ltd, North Office, Wilson House, Crab Lane, Fearnhead, Warrington WA2 0XP**
1	**CORONER** I am Oliver Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern)
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 25/01/2024 I commenced an investigation into the death of Ali Mohammed Nazemi, aged 53. The investigation concluded at the end of the Inquest on 17/09/2024. The conclusion of the Inquest was that this was a death due to natural causes, the certified cause of death being 1a) Sepsis leading to multi organ failure; b) Aspiration pneumonia c) Acute stroke 2) Ex-intravenous drug use.
4	**CIRCUMSTANCES OF THE DEATH** Mohammad Nazemi died from natural causes on 18th January 2024 in Pinderfields Hospital where he had been admitted from home the previous day having sustained an acute stroke and aspirated in the early morning. Paramedics were called some hours after the onset of symptoms. Mr Nazemi's transfer to hospital was delayed when he and the attending paramedics became trapped in the lift at his home address, the oxygen that he was receiving from the paramedics running out before they were rescued, and being restored when he was placed in the ambulance. On the balance of probabilities, he was so unwell by the time of the paramedics' first attendance that the delay in his arrival at hospital did not cause or contribute to the already inevitable outcome.
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 lift that trapped Mr Nazemi and the attending paramedics is identified in an e-Worksheet generated by Schindler (copy attached) as a 20049625 MOD Replacement 6300. The lift was examined by Schindler on the day of the incident, and it was found that "the uncontrolled movement device had been activated by persons using the lift". The lift was

	being used by four paramedics who were transporting Mr Nazemi in a carry chair, the lift being too small to accommodate a stretcher. None of the paramedics were aware of having activated the uncontrolled movement device. The evidence suggested that that was no way to reset the uncontrolled movement device once it had been activated, and that a call to the 24/7 helpline displayed in the lift could not help. Ultimately those trapped within the lift had to wait for the Fire & Rescue Service to break the lift door down. Although Mr Nazemi was so ill that the 45 minute delay caused by the activation of the uncontrolled movement device made no difference to his outcome, there is a concern that others in his position may be seriously affected by the unintentional (and unnoticed) triggering of the uncontrolled movement device and by the fact that nothing apparently can be done to reverse any such unintentional triggering, such that those affected have to await rescue by the Fire & Rescue Service.
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 13/11/2024. 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:- Yorkshire Ambulance Service; Wakefield District Housing. I have also sent it to the West Yorkshire Fire and Rescue Service 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	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 18 September 2024