

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. International Academies of Emergency Dispatch.
1	CORONER I am Mr Andrew Walker, senior coroner for the coroner area of Northern 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.
3	INVESTIGATION and INQUEST On the 11 November 2024 I commenced an investigation into the death of, William John Puplett, aged 78. The investigation concluded at the end of the inquest on 01 October 2025. The conclusion of the inquest was <i>Consequences of a blocked tracheostomy tube at home where there was no working suctioning equipment.</i> The medical cause of death was 1a Hypoxic Brain Injury, 1b Respiratory arrest from block tracheostomy tube, II Laryngeal cancer
4	CIRCUMSTANCES OF THE DEATH On the 9th November 2024 William John Puplett awoke in respiratory distress as his tracheostomy tube had become blocked and an ambulance was called at 5.06 hrs. The ambulance arrived at 6.45 to find that Mr Puplett had no pulse and had stopped breathing. Mr Puplett did not have a working suction unit at his home when he needed it on the 9 th November 2024. Mr Puplett was taken to hospital where, having suffered a significant hypoxic injury, and despite treatment he died the same day. It is likely that had the ambulance arrived before 6.20 when Mr Puplett's heart stopped, he may not have died when he did.

5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – Consideration by the International Academies of Emergency Dispatch to add the following questions when dealing with a patient out of hospital or at home with a tracheostomy tube where there are difficulties with the tracheostomy tube and the patient is experiencing difficulty in breathing. “Have you got suction equipment available and is there someone with the patient who is able to use the suction equipment ? And where the answer is no to either or both the result should be a Category 1 response .
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 Wednesday 03 December 2025 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: 1. [REDACTED] – London Ambulance Service legal representative 2. The family. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	DATE: 10th October 2025
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