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:** **Mr Philip Simpkins** **Chief Executive** **Bedford Borough Council** **Borough Hall** **Cauldwell Street** **Bedford** **MK42 9AP**
1	**CORONER** I am **Ian Pears**, Assistant Coroner, for the Coroner Area of Bedfordshire & Luton
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 11th March 2014 the Senior Coroner commenced an Investigation into the death of **Ernest Charles Harper**, aged 91. The Investigation concluded at the end of the Inquest on 7th May 2014. The Conclusion of the Inquest was that Mr Harper died as a result of [medical cause of death]: Ia Acute Pulmonary Oedema b Lower Respiratory Tract Infection c Right Subdural and Subarachnoid Haemorrhage following a Fall which injuries were caused as a result of him falling from a tailgate lift of a small minibus, operated and forming part of Bedford Borough Council's Accessible Transport Fleet.
4	**CIRCUMSTANCES OF THE DEATH**

	On the 20th February 2014 Mr Harper had been collected from his home address via the Council's accessible transport - a minibus – to visit the Goldington Day Care Centre. His mobility was such that he used a zimmer frame and/or a trike. Mr Harper was aged 91 at the time. On his return, with the aid of a Passenger Transport Assistant, he manoeuvred onto the tailgate lift using his trike, but fell to his side and off the tailgate, between a safety support and the back of the vehicle.
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) That it was possible to fall between the safety barrier and the back of the vehicle (2) That details of a passenger's health and/or mobility (for the purpose of risk assessing the passenger's safety when accessing and egressing the vehicle) is dependant upon information supplied voluntarily by the passenger and/or his family rather than by a formal assessment
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as Chief Executive of Bedford Borough Council, 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 **4th July 2014**. 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.** I have also sent it to [redacted] (son of the deceased) 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	**Dated 9th May 2014** **Ian Pears** **Assistant Coroner** **Bedfordshire & Luton**