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. The Waterway Manager, North West Waterways Canal & River Trust** **2. [redacted]** **3. The Chief Coroner**
1	**CORONER** I am Robert Turnbull, senior coroner for the coroner area of North Yorkshire Western Area.
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 17th January, 2014, I commenced an investigation into the death of Ian Sidney Martin, aged 68. The investigation concluded at the end of the inquest on 8th April, 2014. The conclusion of the inquest was Ian Sidney Martin died as a result of an accident. The medical cause of death was Traumatic head injury.
4	**CIRCUMSTANCES OF THE DEATH** Shortly before 18:30 hours on 9th January, 2014, Mr Ian Sidney Martin was making his way from Skipton Bus Station to Tescos store to meet his wife. It was dark and had been raining and the ground was very wet. From the Bus Station Mr Martin used the canal bridge which leads up to Gas Street, Skipton. He fell on the wet, slippery and worn steps on the bridge sustaining a head injury from which he died in hospital later that day. At the inquest evidence was heard about other people slipping on these steps or avoiding them in wet weather realising they were dangerous. Post-mortem reports and toxicology reports confirm that Mr Martin was in good health and had not been drinking at the time of the incident.
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 condition of the steps from the canal bridge leading to Gas Street, Skipton, presents a danger to those using the bridge. (2) The poor lighting in the area of the bridge.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR

	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 26th June, 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 and to the following Interested Persons: [redacted]. 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	**1st May 2014** R D Turnbull. **Robert Turnbull**