Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Pinner & District Community Association Pinner Village Hall Chapel Lane Pinner HA5 1AA
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 8th January 2014 I opened an investigation into the death of Michael John Harrison , 80 years old. The inquest concluded on the 9th July 2014. The conclusion of the inquest was "Accident", the medical case of death was 1a Head Injury, and under paragraph 2 Pulmonary Embolus.
4	**CIRCUMSTANCES OF THE DEATH** Shortly before 10.49 hrs on the 20th December 2013 Michael John Harrison slipped on black ice and fell striking the back of his head on the ground causing a serious injury, in the car park outside the village hall Chapel Lane, Pinner. London Ambulance service attended and reported that there were patches of black ice in the care park, which made driving, and getting to the patient difficult. Mr Harrison was taken to hospital, transferred to a specialist hospital where he died on the 2nd January 2014
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.

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	The **MATTERS OF CONCERN** are as follows. – That there were insufficient measures to treat the ice that had formed in the car park.
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 Wednesday 3rd September 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;- Members of Mr Harrison's family, 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	**9th July 2014**