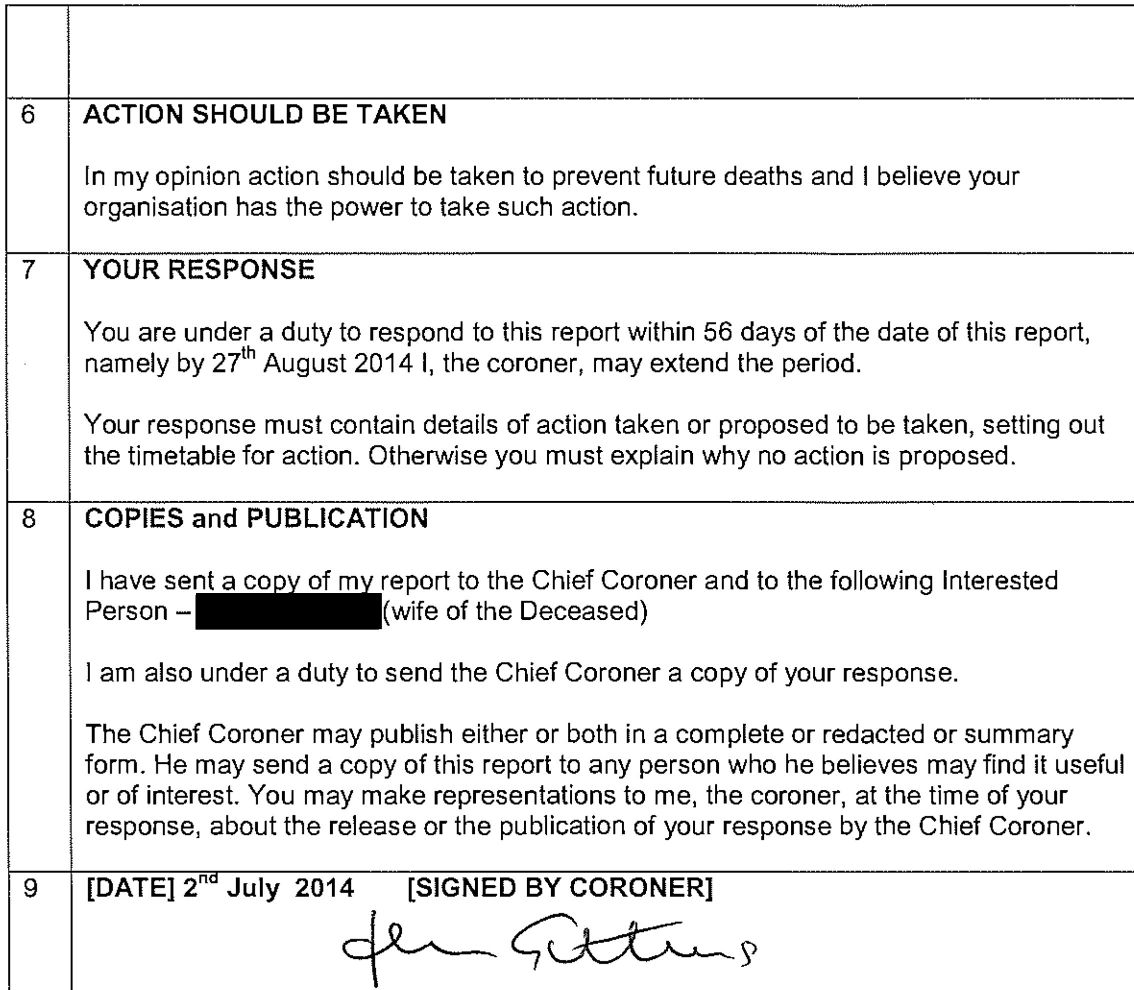
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, Denbighshire County Council, County Hall, Wynnstay Road, Ruthin LL15 1YN
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)]
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 6th of January 2014 I commenced an investigation into the death of Garry Arthur Colin Daltry (DOB 14.2.1949 DOD 1.01.2014). The investigation concluded at the end of the inquest on the 17th of June 2014 and I recorded a conclusion of an Accidental Death with the cause of death being 1(a) Blunt Force Head and Neck Injuries
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that the Deceased had left a New Year's Eve Party at the Beaches Hotel, Prestatyn and had walked along the promenade in the direction of Rhyl where he had tripped over a low wall, falling over the wall onto the ramp below which provides access to the beach front. As a result of this fall he sustained blunt force injuries to his head and neck which resulted in his death at the scene.
5	**CORONER'S CONCERNS** During the course of the inquest, evidence given by the family of the Deceased, which was further confirmed in photographic evidence provided by them [redacted] showed that the wall over which Mr Daltry fell was neither lit nor protected by railings and could therefore reasonably be considered to pose a tripping hazard, as proved to be the case on this occasion. 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 :- That unless steps are taken to mitigate the tripping hazard in this location, then other people may fall sustaining injuries which could lead to future deaths.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 27th August 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 Person – (wife of the Deceased) 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	**[DATE] 2nd July 2014 [SIGNED BY CORONER]**