

# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

#### **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

- 1. Head of Trading Standards, Oldham Metropolitan Borough Council
- 2. Trading Standards Institute
- 3. Department for Business, Innovation & Skills (Consumer Safety)
- 4. Chief Executive, Public Health England

## 1 CORONER

I am Assistant Coroner for the coroner area of Manchester North

#### 2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

## 3 INVESTIGATION and INQUEST

On the 29<sup>th</sup> October 2013 I commenced an investigation into the death of Sindy Louise Woodhall.

#### 4 CIRCUMSTANCES OF DEATH

The deceased had long standing addictions to alcohol and Butane and Propane and was known to misuse the latter gases on an extremely regular basis.

On the 24<sup>th</sup> October 2013, the deceased was found in a collapsed state, in the street near to her home, by a passer-by. Ms Woodhall was taken to hospital but subsequently died. Post mortem examination and toxicology confirmed the medical cause of death to be 1a) Butane and Propane Inhalation Toxicity.

# 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:-

- During the course of the inquest, it transpired that cans of the aforementioned gases were being sold to the deceased by local retailers who were fully aware of her addition/problems. Whilst morally reprehensible, there was no law to prevent them from selling large amounts of the toxic/potentially fatal gases to the deceased.
- 2. Lack of regulation.
- 3. No powers afforded to Trading Standards to take action/prosecute.
- 4. Risk to public health.

# 6 ACTION SHOULD BE TAKEN

7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely the 27 <sup>th</sup> 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 Persons namely the deceased's next of kin and the Senior Investigating Officer, Greater Manchester Police.
	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 from. 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: 1 <sup>st</sup> July 2014 Signed: