REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted] **Head of Planning & Regulatory Services, Isle of Wight Council.** 2. [redacted] **Environmental Health Officer, Isle of Wight Council.** 3. [redacted] **Manager of the "Off The Rails Café" Yarmouth, Isle of Wight.** 4. [redacted] **Owner of the "Off The Rails Café" site.**
1	**CORONER** I am John Arthur Matthews, Assistant Coroner for the Coroner Area of the Isle of Wight.
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 27th September 2014 I commenced an investigation into the death of John Ramsay Darling, aged 84. The investigation concluded at the end of the inquest on 27th January 2015. The conclusion of the inquest was "Accidental Death". The medical cause of death was found to be: 1a Cardiac Arrest / Acute Cardiac Failure 1b External Bleeding from Traumatic Injuries to the Forehead and Nose 1c 2 Ischaemic Heart Disease with Stenosing Atherosclerosis of Coronary Arteries and Myocardial Scar.
4	**CIRCUMSTANCES OF THE DEATH** 1) John Ramsay Darling was born on 14th August 1930. At the time of his death, he was 84 years of age. 2) At the time of his death, he had a number of significant health issues, including atrial fibrillation and chronic cardiac failure. He was wheelchair bound due to his osteo-arthritis and was fitted with a long-term catheter. He had spent a considerable period on hospital, from January 2013 before continuing his

convalescence in a rehab nursing home. With medication, his condition had stabilised.

3) On Saturday 27th September 2014, sometime after 12.30 p.m. Mr Darling left his house with his daughter [redacted] grand-daughter, [redacted] and two family dogs. They went for lunch to the "Off The Rails Café" in Station Road, Yarmouth, Isle of Wight, which had opened for business on 4th August 2014. This Café was situated in a newly restored railway station on a disused line. There were no railway tracks remaining below the platform, only a pathway / cycle track.

4) Mr Darling, his daughter and grand-daughter chose to sit at a round table on the old rail platform outside the Café. They enjoyed a meal together, and consumed water with their meal. The Café was very busy whilst they were there.

5) Upon finishing their meal, [redacted] moved her father's wheelchair out from under the table and positioned him to face towards the Tennyson Monument which was just off-parallel with the edge of the platform.

6) [redacted] then turned away from her father to untie the dogs. She gave them to her daughter and told her to walk them away from other patrons with dogs. As she turned back to face her father, she saw his wheelchair moving over the edge of the platform. Mr Darling was still seated in his wheelchair as it rolled over the edge. The drop from the top edge of the platform to the ground below was approximately a metre. There were no barriers to prevent this situation from occurring.

7) [redacted] rushed to her father's aid. He was found to be lying on his side with his face on the path below the edge of the platform. He was bleeding from a head injury. He was unresponsive and pale.

8) The Fire Brigade attended approximately 5 minutes later and were joined by an Ambulance. First aid and CPR was administered. [redacted] was aware that there was a DNACPR in place for her father after his last heart attack.

9) Mr Darling was taken to hospital by Ambulance. He did not recover consciousness and was pronounced dead by Advance Nurse Practitioner Shane Moody at 16.48 hours on 27th September 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.

	The **MATTERS OF CONCERN** are as follows: – 1. The "Off The Rails Café" has a platform which has an unguarded edge with a drop of approximately a metre onto the area where the railway track used to be. Whilst there is a painted warning on the ground at the point of the edge, I am concerned that this is an accident which is almost inevitably going to reoccur as there is nothing to stop anyone falling over the edge. 2. A painted warning sign on the platform edge warning of the danger is of no use to those who are in baby buggies, or to toddlers or small children who may easily fall off the edge, or to someone who accidentally walks back over the edge. 3. I am concerned that at busy times, it would be all too easy for someone to lose their footing and stumble off the edge of the platform. 4. Whilst the manager of the Café, [redacted] gave evidence that more staff would be employed to usher patrons to their seats, it should be mentioned that this incident did not occur because of a lack of staff, but because of the unguarded platform edge. 5. I am further concerned by the slight incline on the platform towards the edge, which is visible on the plans, which was instituted to make it easier for disabled patrons to enter the Café and to avoid the necessity for a step into the premises. The slight incline would increase the risk of a buggy or wheelchair leaving the premises being able to pick up speed and head directly towards the edge of the platform. 6. It should be mentioned that the Isle of Wight Council Planning Department had not requested that any physical measures in the form of a barrier or balustrade be implemented to protect patrons from falling off the edge of the platform, notwithstanding that there had been three objections (later withdrawn) from members of the public at the Planning and Licensing Consultation stage. Clearly, with the Café open for less than 2 months before this fatality occurred the position adopted by the Isle of Wight Planning Department is untenable and needs to be reviewed.
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 31st March 2015. 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	 **H.M. Assistant Coroner – Isle of Wight** **3rd February 2015**