REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Mike Coupe, Chief Executive.** **J Sainsbury's plc.** **Sainsbury's Store Support Centre,** **33 Holborn, London, EC1N 2HT.** **2. Mr Mark Hall, Chief Executive,** **Oadby and Wigston Borough Council,** **Station Road, Oadby,** **Leicestershire. LE18 2DR** **3. Mr Richard Judge, Chief Executive** **Health and Safety Executive,** **Redgrave Court, Merton Road,** **Bootle, Merseyside.L20 7HS.**
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and Leicestershire South
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 March 2015 I commenced an investigation into the death of Belinda Jane Wise. At inquest the determinations were that; On the 6th March 2015 at Sainsbury's, Glen Road, Oadby, Belinda entered the lift. Belinda leant against the rear doors and subsequently fell backwards when the doors opened hitting her head. There were no sign/auditory warnings within the lift to indicate the rear doors would open. Belinda died on the 11th March 2015 at University Hospital, Clifford Bridge Road, Coventry and Warwickshire of a left-sided subdural haemorrhage. Conclusion – Accidental death Cause of death 1a Left sided subdural haemorrhage 1b Fall
4	**CIRCUMSTANCES OF THE DEATH** Mrs Wise was taking warfarin for a diagnosed cardiac condition. She arranged to meet a friend for lunch at a Sainsbury's café and entered the lift to take her to the mezzanine level within the store. She recollected leaning on the lift side, and being surprised when rear doors opened, opposite to where she had entered the lift. There was no sign or auditory warning to alert the passengers of this. She stumbled and fell to the floor, banging her head. Initially she was attended by the store First Aid responder, but appeared to be uninjured.

	However, a short time later she became unwell and an ambulance was summonsed. She was taken to the local neurosurgical centre for suspected brain injury, and on arrival was deeply unconscious and CT scanning revealed a large subdural haemorrhage with mid line shift. Her condition was thought to be unsurvivable; she was palliated and died 5 days later.
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. – It was a finding of the jury that there were no signs or auditory warnings within the lift to indicate that the rear doors would open. Evidence taken from the Sainsbury's store and from the Borough Council investigation confirmed that such warnings are not standard or mandatory. In this instance, it was clear from the Evidence that the deceased did not appreciate that the part of the lift that she was leaning was actually the rear doors, as they were not marked in any way. Further consideration should be given to the possibility of making the doors more apparent and distinguishable from the rest of the interior, and also to the sounding of a warning message (that may assist visually impaired passengers).
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 11th April 2016. 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] (Family) Chief Executive, University Hospitals Coventry and Warwickshire. 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]** **[SIGNED BY CORONER]** **15th February 2016**