ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

The Inquest Touching the Death of Isaac John Walter Brocklehurst

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The state of the s	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. Incommunities
1	CORONER
and the department of the depa	I am Martin Fleming, HM Senior Coroner, for the Coroner Area of West Yorkshire (Western)
2	CORONER'S LEGAL POWERS
mercen mineral in the state of	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 1 st April 2016, I opened an Inquest into the death of Isaac John Walter Brocklehurst who, at the date of his death was age 2 years old. The inquest was resumed and concluded on the 10 th October 2016. I found that the cause of death to be:-
	1a – Multiple Injuries
	Conclusion of the Inquest was:-
	Accident
4	CIRCUMSTANCES OF THE DEATH
	At approximately 12.30pm Isaac was sat playing on his ride along 4 wheeled plastic Bike on pathways within a community grassed area located at the rear of his grandmother's residence at
	Isaac was playing on a pathway which runs from the back door of the flat, passed the bins, to a gap in a low brick wall which enables pedestrian access to the pavement and lay-by used by residents to park their cars.
	Isaac suddenly and unexpectedly wheeled through the pedestrian gap in the wall, along the pavement, before then emerging between two parked cars into the path of a Scania tipper lorry which was being driven along Valley Road at approximately 13.05pm, causing Isaac to instantaneously sustain fatal injuries in circumstances such that both grandmother and driver were unable to take evasive action.
5	

CORONER'S CONCERNS The Inquest heard evidence to suggest that children play within the communal grassed area at the rear of The Integrity of the low parimeter wall or it's maintenance was not brought into question. The MATTERS OF CONCERN is as follows. -To review the existing pedestrian gaps in the parimeter wall in order to assess the safety aspects for children. 6 **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, I believe you the Local Authority have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of it's date, I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. **COPIES and PUBLICATION** 8 I have sent a copy of my report to - Mother - Uncle Grandfather - Collision Investigator Chief Coroner 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. [SIGNED BY CORONER] M. D. Fleues