ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Simon Hodgson, Chief Executive, National Tree Safety Group, Forestry Commission, 620 Bristol Business Park, Coldharbour Lane, Bristol, BS16 1EJ**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the coroner area of West Yorkshire (Eastern)
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 12th November 2010 I commenced an investigation into the death of Elaine Edith Davison, aged 55. The investigation concluded at the end of the Inquest on 21st June 2017. The conclusion of the Inquest was a Narrative Conclusion including the medical cause of death of 1(a) Abdominal Haemorrhage due to (b) Penetrating injury to the Abdomen. I attach a copy of the Jury's findings in respect of their Narrative Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** On 11th November 2010 Elaine Edith Davison was the front seat passenger in a car driven by her husband. At approximately 8.25pm they were travelling along the A642 Aberford Road, Wakefield, West Yorkshire and were passing the grounds of a disused churchyard called St Peter's, which is the responsibility of Wakefield Council to maintain. It was a stormy night with gusts of wind up to 90 miles an hour. Part of a tree fell onto the car, a part of which penetrated the windscreen, and entered Mrs Davison's abdomen, causing her to sustain fatal injuries, her death being confirmed at 2130 hours on 11th November 2010.
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 subject tree had been examined on several occasions and had been diagnosed as suffering with Phytophthora Pseudomonas, more commonly referred to as bleeding canker. The tree had been given a life expectancy of between nought and ten years. At that time it was not considered to be a danger, but will have ultimately been felled.

	(2) Post incident the tree was examined by an expert Arboriculturalist who determined that the tree was severely decayed at 8.5 metres in height with insufficient sound timber at this point to support the weight of the tree. The decay was caused by a fungal infection Polyporus Squamosus. The decay was longstanding and progressive. The decay was hidden from sight, but the tree contained visible defects worthy of closer inspection, which would have led to the discovery of this condition, and a recommendation for it to be felled as a matter of urgency. (3) I am informed that your view is that the risk of people being killed by falling trees is extremely low, in fact one in ten million, but you recognise the duty of holders who are required to take reasonable steps to minimise the risk. Notwithstanding this I recommend that your organisation as having a major influence nationally on tree safety, bring to the attention of those who are responsible for the upkeep and maintenance of trees, particularly in places frequented and used by the public, and for trees that are abut and overhang a highway, when such a tree or trees are recognised as having fault or disease, that such trees are automatically examined and tested for Polyporus Squamosus and if such a disease is identified then the tree should be recommended for felling. (4) It is apparent that the condition Polyporus Squamosus may well be mistaken for the more common condition Phytophthora Pseudomonas or bleeding canker, and the urgency of felling might not be considered. (5) It would be helpful if you would bring this case and my recommendations to those organisations that you can influence.
6	**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 6th September 2017. 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, Minton Morrill Solicitors, BLM Law Solicitors and Weightmans Solicitors. 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	**12th July 2017** **[SIGNED]** David Wright.