REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Wolverhampton City Council** **2. Transport for West Midlands, West Midlands Combined Authority.** **3. West Midlands Fire Service, Black Country North Fire Safety team.**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 8 November 2017, I commenced an investigation into the death of Mr Christopher Brookes. The investigation concluded at the end of the inquest on 22 February 2018. The conclusion of the inquest was a short narrative conclusion of: Accident The cause of death was: 1a Cranial Trauma
4	**CIRCUMSTANCES OF THE DEATH** i) Mr Brookes was a 22 year old gentleman who had been out socialising on the 28 October 2017 celebrating a family birthday. ii) He later made his way to the Wolverhampton bus station and around 2am left the station via a fire exit. iii) It appears from the evidence available he tried to climb over a gate whilst leaving through a fire exit and then fell around 40 feet to the road below. iv) He was taken by ambulance to the Queen Elizabeth Hospital in Birmingham, but sadly died from the injuries sustained on the 29 October 2017.
5	**<u>CORONER'S CONCERNS</u>** 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. Evidence emerged during the inquest that there was a previous incident at the same location involving a member of public who narrowly escaped falling to the road below in April 2017 in similar circumstances. 2. Evidence also emerged during the inquest that an alarm would be activated if the fire exit was used. It appears that security guards employed to deal with unauthorised use of the fire exit failed to attend.
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. 1. You may wish to consider further reviewing the safety arrangements in place at this location and consider what additional measures can be put into place to try and prevent a reoccurrence.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 April 2018. 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; Family. 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	**22 February 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**