for Bedfordshire & Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO:	
	M&S Water Services (Utilities) Limited Unit 6 High Town Enterprise Centre York Street Luton Bedfordshire LU2 OHA	**B&D Civil Engineering Limited** Ghost Barn Hoo Farm High Street Hitchin Herts SG5 3ED
1	**CORONER** I am, Ian Pears, Acting Senior Coroner for Bedfordshire & Luton	
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made	
3	**INVESTIGATION and INQUEST** On 1June 2017 I commenced an Investigation into the death of **Matthew James WILMOT** aged 40 years. The Investigation concluded at the end of the Inquest on 12 April 2018. The conclusion of the Inquest was 'Accidental Death'. The medical cause of death was: I (a) High blood ethanol concentration consistent with significant intoxication together with fatal hypoxia	
4	**CIRCUMSTANCES OF THE DEATH** The deceased went out for the afternoon/evening to watch the FA Cup Final with friends. A friend travelled back with him by taxi, dropping him off near his home	

	at 00.45 hours on 28th May 2017. At 07:14 hours a call was made to the Ambulance Control from the resident of 280 Devon Road, Luton, Bedfordshire, stating that the deceased was upside down in a hole outside her house.
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 : The accident happened on a path which had been excavated to find a stop cock. The excavation had been abandoned as a Deep Excavation Team was required. The path was closed by placing a sign at each end of the path stating that the path was closed. The hole and spoil were fenced off by using a metal railed fence which was alongside the path and 4 plastic yellow barriers which were secured to the metal fence. A risk assessment had taken place. The evidence was that the risk assessment was in line with the Red Book and Industry Standards. The Red Book encourages a risk assessment based on the locality, footfall, etcetera. My concern is that not enough consideration was given to the nature of the path. To all intents and purposes there are two types of paths. The most common is the path that runs parallel to a highway. If that path is closed, the pedestrian can be guided around the excavation or told to cross the road. It is unlikely that the pedestrian would walk through a barriered area in such circumstances as that would be slower than walking around it. The second type of path is one that is unique in its journey from A to B, ie there is no road to the side. This particular path lead from the road to a row of houses, which were not accessible by road. The alternative route (which was not signposted) was 150 metres away, meaning a diversion of about 300 metres. The path was not located in an area of risk. However, my concern is that a route that is unique is always at risk as pedestrians will want to travel the shortest route. This is backed up by the evidence in the Inquest which recorded 9 pedestrians (including the deceased) travelling through the closed path in the 7 hours before the deceased was found. The excavators took photographs of the site just before they left it. Looking at those photographs, I would have risked walking down the closed path. My concern is that there is not enough emphasis within the risk assessment process that a route that is unique has different risks to a path that is parallel.

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 **29 June 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: • Amey Utility Services Limited • Affinity Water Limited • The Department of Transport • [redacted] (partner of the deceased) 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	**Dated 17 April 2018** H.M. CORONER BEDFORDSHIRE AND LUTON **IAN PEARS** Acting Senior Coroner for Bedfordshire & Luton

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