	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Construction Industry Council (CIC), The Building Centre, 26 Store Street, London WC1E 7BT**
1	**CORONER** I am Leslie Hamilton, assistant coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 06.06.2017 I commenced an investigation into the death of Glynn Matthew Storey, 32 years. The investigation concluded at the end of the inquest on 27 July 2018. The conclusion of the inquest was Accident. The medical cause of death was :- 1a. Injuries to back. 1b. Fall from a height
4	**CIRCUMSTANCES OF THE DEATH** The deceased was staying with a friend (in a flat with which he was not familiar). During the night, under the influence of alcohol, he fell from a second floor window onto a fence below sustaining fatal injuries. The window did not meet building regulations (it was a low window and did not have a safety guard/opening restrictor fitted). Further investigations revealed that none of the 40 flats in the development, completed in 2011, had safety devices fitted. Local remedial action has been taken.
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) There is confusion as to whether the approved building control inspector or the builder is responsible for ensuring that such windows meet building standards. Detailed enquiries by the police have shown that responsibility lies with the builder/owner. However, the owner/builder felt that as the building had been inspected on multiple occasions, all safety standards had been met.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. There needs to be absolute clarity as to how is responsible for ensuring that buildings meet safety standards.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st September 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 Shakespeare Martineau LLP acting for Cockerton Green Developments. I have also sent it to [redacted] who may find it useful or of interest. 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	**27.07.2018** **Dr J R L Hamilton** **HM Assistant Coroner** **County Durham and Darlington**