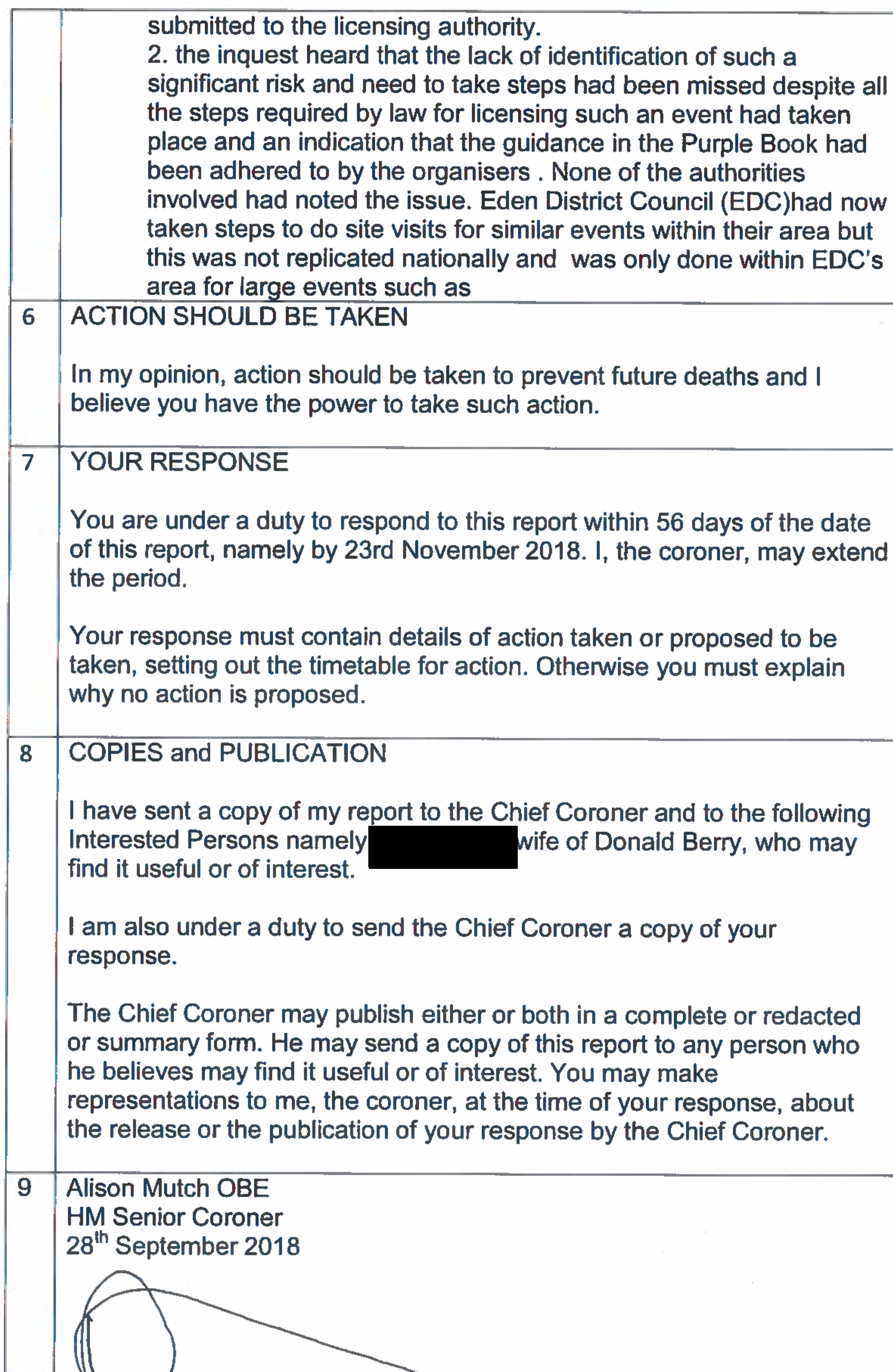
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Business, Acting Chief Executive for HSE and Director of Kendal Calling
1	CORONER I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester
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 24th August 2016 I commenced an investigation into the death of Donald Peter Berry. The jury inquest concluded on the 6th September 2018 and the conclusion of the jury was one of accidental death The medical cause of death was: 1aBronchopneumonia; 1bRecurrentChest Infections; 1 c Immobility due to paralysis II Epilepsy due to traumatic brain injury caused by electrocution
4	Donald Berry suffered severe injuries due to being electrocuted whilst working at the Kendal Calling Festival on 22nd July 2010. These injuries resulted in ongoing health complications leading to his death on 23rd August 2016 at St Mark's Care Centre 28 Delaunays Road, Sale.
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.The inquest heard that the organisers of the event Kendal Calling had not identified that a clearly visible high voltage power line was running over the site and no steps had been taken to minimise the risk although an Event Safety Plan had been



	submitted to the licensing authority. 2. the inquest heard that the lack of identification of such a significant risk and need to take steps had been missed despite all the steps required by law for licensing such an event had taken place and an indication that the guidance in the Purple Book had been adhered to by the organisers . None of the authorities involved had noted the issue. Eden District Council (EDC)had now taken steps to do site visits for similar events within their area but this was not replicated nationally and was only done within EDC's area for large events such as
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 23rd November 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 namely [redacted] wife of Donald Berry, 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	Alison Mutch OBE HM Senior Coroner 28th September 2018