REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Trafford Metropolitan Borough Council, The Group Managing and Director of Manchester United Football Club and The Chief Executive of Digital, Culture Media and sport
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 11th December 2017 I commenced an investigation into the death of Richard John Whale. The jury inquest concluded on the 22nd November 2018 and the conclusion of the jury was one of accidental death (contributed factors) 1.Impedance of the exit by the stewards.2.Obstruction of access to both handrails by stewards.3.Lack of awareness by the stewards of their surroundings The medical cause of death was 1a Traumatic subdural haemorrhage (head injury); 1bFall
4	Mr Whale died at Salford Royal Hospital at 20:17pm on the 11th December 2017 as a result of a head injury caused by a fall down the exit stairs at Old Trafford football ground the previous day.
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 Local Authority had issued a list of recommendations to the club after the death of Mr Whale. There was no mechanism in place for discussion of those recommendations or to ensure that they had been followed or if not followed discussion for reasons.

	2. The widths of the staircases ("vomiteries") is set in the Green Guide. Those widths take into account the handrails but not the inevitable reduction in width that takes place when stewards are deployed into them. In effect, the vomiteries are significantly narrower at points than the suggested widths. 3. The green guide does not give guidance as to placement of stewards or suggest best practice to avoid stewards blocking access to the handrails. It was accepted during the course of the inquest that the role and placement of stewards was vital to ensuring the safety of the public at football matches. 4. It was accepted by MUFC that the club stewards were not complying with the code of conduct relating to stewards although one was trained and one was undergoing training. A supervisor was also supervising them. There was no evidence of regular audits of stewards and their compliance with the Code of Conduct.
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 8th February 2019. 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 Mrs June Whale wife of the deceased, 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 21/12/2018