ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Crossings Project, 55 Great Union Street, Kingston upon Hull
1.	**CORONER** I am **Rosemary Jane BAXTER**, Area Coroner, for the coroner area of the City of Kingston upon Hull and the County of East Riding of Yorkshire.
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 July 2018 I commenced an investigation into the death of **Bryan GRAY** aged 31 years. The investigation concluded at the end of the inquest on 12th February 2019. The conclusion of the inquest was **OPEN CONCLUSION** including medical cause of death was 1a) Extensive internal injuries due to 1b) Fall from height.
4.	**CIRCUMSTANCES OF THE DEATH** The deceased fell from a third floor window at The Crossings, 55 Great Union Street, Kingston upon Hull in the early evening of 21st July 2018. As a result of this fall, he sustained multiple injuries incompatible with life and died in Hull Royal Infirmary later that day.
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) The deceased fell from a window. It was unclear whether a window restrictor was in place at the time of the incident or if this had been broken by him to enable him to climb over the window ledge It is understood that this window restrictor has since been replaced with a wire cable type but it was established during the investigation that the other windows within the building did not have any window restrictors in place.

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.
7.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th April 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, [redacted] (mother); Humber NHS Foundation Trust. 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.	**[DATE]** 12 February 2019 **[SIGNED BY HM Area Coroner]** Rosemary J. Baxter. **Rosemary Jane BAXTER**