	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]
1	**CORONER** I am Tim Holloway Assistant Coroner for **Blackpool & Fylde**
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 06/09/2018 I commenced an investigation into the death of Christopher BEVAN. The investigation concluded at the end of the inquest held on 12th-14th March 2019. The conclusion of the inquest was that the Deceased died as a consequence of an accident and that the medical cause of death was: 1(a) Diffuse brain swelling (operated) 1(b) Blunt head trauma with skull fractures
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death, as determined by the jury, were that on 14th August 2018 between 1500hrs and 1540hrs at [redacted] the Deceased was last seen undertaking work to the garage roof whilst on a ladder and that he fell and sustained head injuries. The date of death was 15th August 2018 at 1900hrs at Royal Preston Hospital. The jury's conclusion as to death was "Accident".
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) That ladders may be used in the course of your work (a) in *circumstances* in which their use may present a risk to life *and/or* (b) in a *manner* in which their use may present a risk to life. The Court received evidence to the effect that the ladders in use at the time of the fatal accident on 14th August 2018 were used on a surface which may have been slippery, that they were not footed during use, that they were not secured at the top save to the extent that they were supported by the blockwork and/or by recently laid coping stones of a facing wall above the door opening of the garage and that they may have been used by the Deceased, with whom you had been working, in a manner which involved him assuming an awkward position in order to carry out work. The concern therefore arises that you may use or those with whom you may work may use ladders in circumstances or in a manner which present a risk to you, to them and/or to others.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 15th May 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] 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	20/03/2019 Signature Tim Holloway Assistant Coroner **Blackpool & Fylde**