REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Cadent Gas Ltd, Ashbrook Court, Prolopgis Park, Central Boulevard, Coventry CV7 8PE 2. Wales and West Utilities, Wales and West House, Spooner Close, Celtic Springs, Coedkernew, Newport NP10 8FZ 3. Institution of Gas Engineers and Managers. IGEM House, 26-28 High Street, Kegworth, Derbyshire DE74 2DA 4. Scotia Gas Networks, Inveralmond House 200 Dunkeld Road Perth, PH1 3AQ United Kingdom 5. Gas Safe Network Ltd, Unit 4 + 5 Winston Business Park, Churchill Way, Sheffield S35 2PY
1	**CORONER** Tanyka Rawden, Assistant Coroner for Rutland and North Leicestershire
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** On 2 January 2018 an investigation commenced into the death of Janet Shirley Jasper aged 79 years. The investigation concluded with an inquest heard before a jury between 13 and 17 January 2020. The conclusion of the inquest was accidental death

4	**CIRCUMSTANCES OF THE DEATH** Mrs Janet Shirley Jasper was born on 10.10.38. She resided in a semi-detached property at [redacted] in Birstall, Leicestershire with her husband [redacted], and their son [redacted] The adjoining house, number [redacted] in Birstall, Leicestershire, was vacant, having been owned by the father of the witness [redacted] who died in August 2017 On 10 December 2017 [redacted] reported the smell of gas in his hallway and a first call operative from Cadent Gad Ltd attended the property. The first call operative found no evidence of a gas leak in [redacted] Birstall, Leicestershire On 11 December 2017 [redacted] arrived at number [redacted] at approximately 7.20am. He noticed a smell whilst on the driveway which became stronger as he entered the conservatory, and then the kitchen, of the property. He described lifting the glass lid of the hob and then finding himself lying on the kitchen floor covered in rubble The Court heard from [redacted] that at approximately 7.30am on 11 December 2017 he got out of bed leaving his Mrs Janet Jasper in bed. He was standing the bottom of the bed when there was an "enormous flash and a bang". Plaster board fell on top of him pinning him to the floor Mrs Janet Jasper was taken to Walsgrave Hospital where she died on 12 December 2017 The Court heard from [redacted] Consultant in Intensive Care Medicine that the medical cause of death was: 1a. Multi organ failure 1b. Thoracic trauma 1c. Explosion The Court heard from [redacted] gas investigation officer for the Health and Safety Executive, that the gas leak originated in the hallway of [redacted] Birstall, Leicestershire. A full separation of the gas pipe in the concrete floor of the hallway had occurred due to ground movement caused by subsidence. His evidence was that poor construction of the floor was a major contributing factor in the subsidence and the failure of the pipe [redacted] was unable to assist the court with exactly when the gas pipe failed. He estimated a time period of between five and ten hours but was clear that the time period could have been shorter or longer than that estimate. He was unable to say whether the gas leak had occurred before, or during, the first call operative's visit to number [redacted], Birstall, Leicestershire His evidence was that the spark which ignited the gas and caused the explosion was likely to have omitted from the light switch or the spark ignition on the hob of the cooker in the kitchen

5	**CORONER'S CONCERN** During the course of the investigation my inquiries 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 **MATTER OF CONCERN** is as follows. – The Court heard that there are two hundred and fifty four properties within the immediate area of the incident which are at risk of floors failing in a similar manner The Court also heard there is inconsistency in the policies of the four gas distribution networks with some requiring first call operatives to inspect adjoining properties for gas and some permitting the operative to make that decision based upon the circumstance and findings on scene In my opinion there is a risk that future deaths may occur unless the risk to the other properties within the immediate area of the incident is properly and quickly addressed, and a consistent approach to inspecting adjoining properties is developed
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 13 March 2020. I may extend this period upon your application 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] via his representative Rich and Carr Solicitors, 24 Rutland Street, Leicester LE1 1RD [redacted] via his representative, DAC Beechcoft Sovereign House, Imperial Way, Newport, NP10 8UH The Health and Safety Executive. Redgrave Court, Merton Road, Bootle, Merseyside **L20 7HS** Lloyds Bank Home Insurance via their representatives Hugh James Solicitors, 2 Central Square, Cardiff, CF10 1FS I have also sent a copy to: Charnwood Borough Council, Southfields Road, Loughborough, LE11 2TN 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

Mrs Tanyka Rawden

17 January 2020