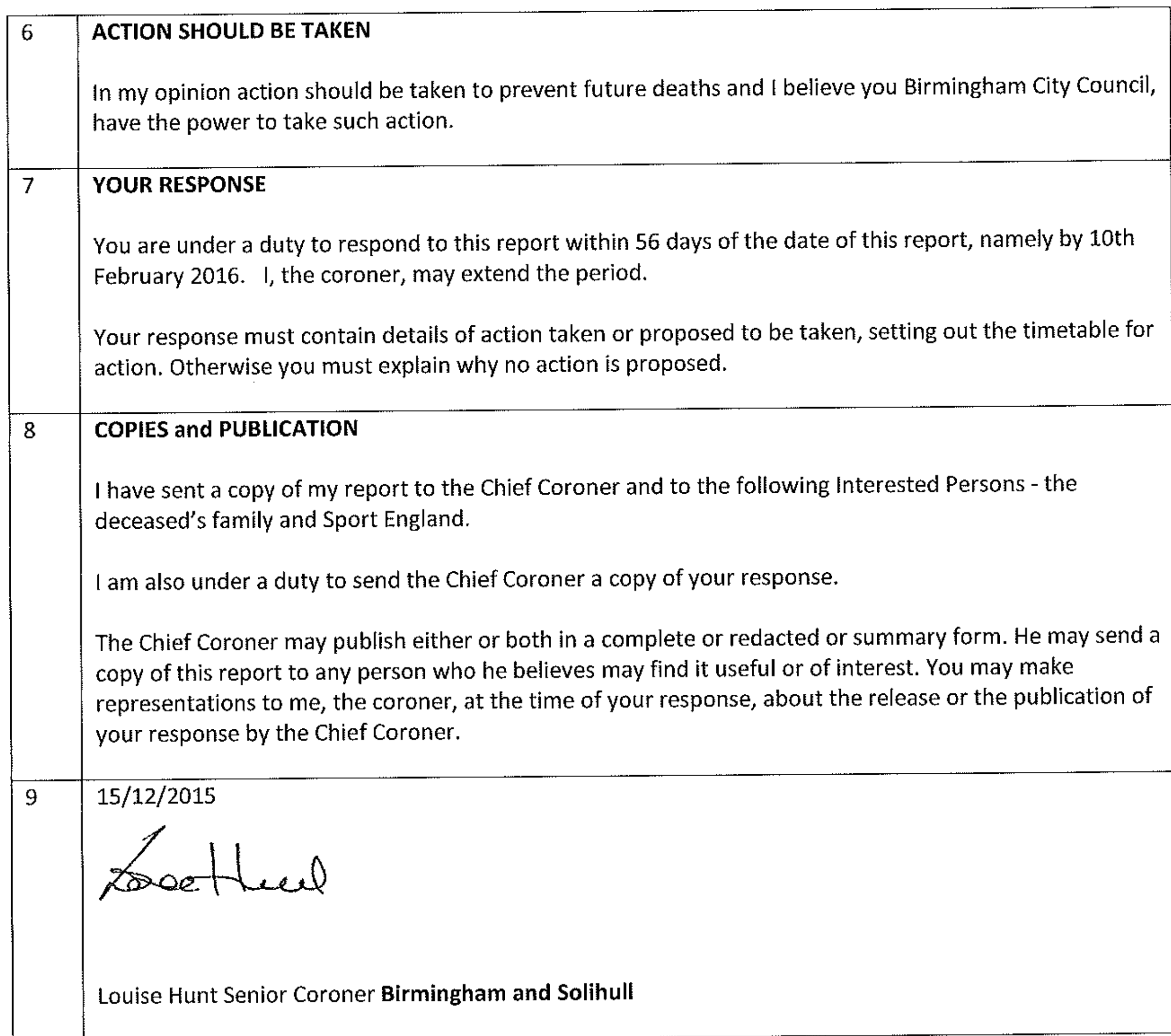
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] – Birmingham City Council
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21/08/2015 I commenced an investigation into the death of Kamrul Hassan RUBEL (DOB 30/12/91) aged 23. The investigation concluded at the end of the inquest 14th December 2015. The conclusion of the inquest was that the deceased as a result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was running on a treadmill at Small Heath Wellbeing Centre on 10/8/15. The treadmill as manufactured by Technogym and the model was Run 700. At approximately 13:00 he was seen to fall of the back of the treadmill hitting his head on the floor. He was taken to Birmingham Heartlands Hospital and later transferred to Queen Elizabeth Hospital Birmingham. He continued to have raised intracranial pressure as a result of the head injury. He required surgery on 15/8/15 but died despite all treatment. The cause of death was TRAUMATIC BRAIN INJURY.
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) During the inquest I heard evidence that during initial gym induction users are advised, in accordance with the manufacturer's instruction, that they attach a cord which acts as an emergency stop if anything untoward should occur. At the time in question the deceased did not attach the cord and evidence confirmed it was not normal practice for the gym to enforce use of the emergency cord. It is impossible to say whether this would have made any difference to the deceased but steps should be taken to ensure that appropriate advice and warnings are given to all users regarding the correct use of the emergency cord.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Birmingham City Council, 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 10th February 2016. 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 - the deceased's family and Sport England. 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	15/12/2015 Louise Hunt Senior Coroner **Birmingham and Solihull**