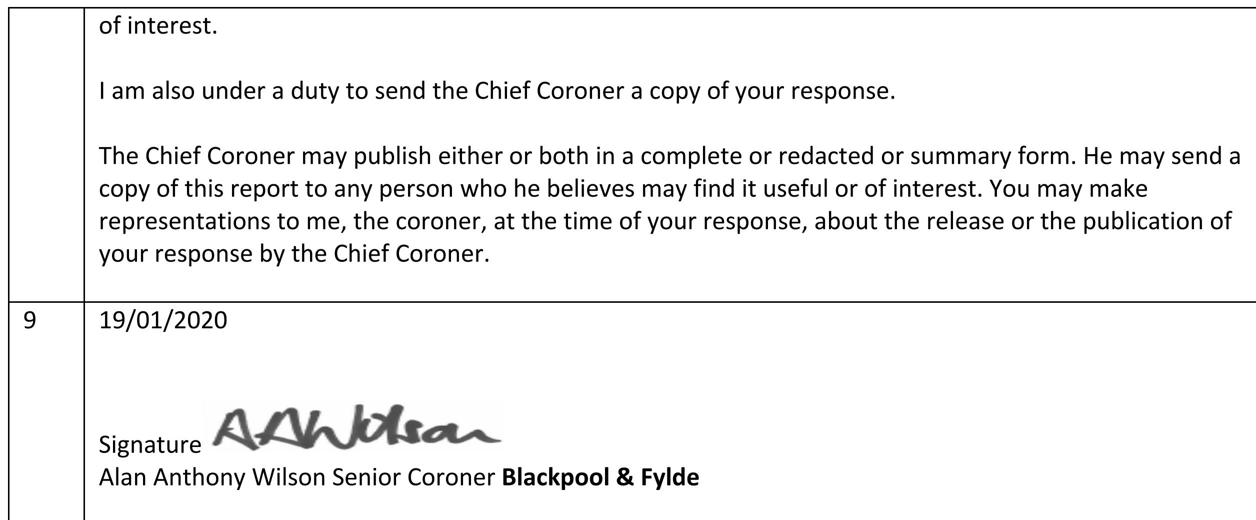
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:**
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 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 15/01/2020 I concluded an inquest into the death of Matthew WILLOUGHBY. I determined that the medical cause of death was: 1a **Multiple Injuries** b **Fall from high altitude** In the Record of Inquest I recorded that: **Matthew Willoughby was observed to lean out of a fourth floor window at the flat where he resided and shout to a passer – by on the afternoon of 9th August 2019 at approximately 15:30hours but inadvertently fell from the window to the ground below where he was found by members of the public in the back yard of the property. An ambulance was contacted and he was transferred to hospital in Preston where it was confirmed that he had suffered significant brain and internal injuries. Despite life-saving efforts his injuries were found to be incompatible with life and he was pronounced deceased at approximately 23.35 hours that evening in the presence of his family.** The conclusion of the Coroner was that Matthew had died due to: **Accidental death.**
4	**CIRCUMSTANCES OF THE DEATH** In addition to the information set out above in part 3, the following is relevant: Matthew was 27 years of age at the time of his death. For approximately 4 years he had resided at in Blackpool. The property is a four story building comprising of a number of flats rented out to tenants by the owners of the property namely and her Husband. For approximately 2 years prior to his death on 9th August 2019 Matthew had resided in a flat on the top floor. The evidence heard at the inquest illustrated that at the time of his death Matthew had fallen from his one external window which overlooks the rear of the property and that the window was capable of being opened sufficiently for a person to climb out of the window should they choose to. The evidence was also clear in that immediately before he fell to his death Matthew had been seen leaning out of his window to what was described by one witness to be a dangerous manner. He was known to be a regular cannabis user but there was insufficient evidence to be able to conclude that he was under the influence of cannabis at the time of the incident to the extent this made a material contribution to the death. attended the inquest and gave evidence. During her evidence she brought to the attention of the court some information not previously mentioned in the witness statement she had provided shortly after this reported death. That information included the following:

	• Matthew as someone who preferred a fresh environment in his flat and was therefore known to keep his flat window open at all times [his Parents who were in attendance at the inquest were in agreement with this.] • Approximately 14 months before his death a Blackpool Council Inspector visited and advised that on grounds of safety the window in Matthew's flat ought to be adapted on the basis that adaptions be added to the window which would effectively restrict how far the window could be opened and that these restrictions would effectively restrict the extent to which the window could open so that it would no longer be possible for a person to climb out of that window. • These adaptions had been added. However in due course Matthew had removed them. He was unhappy that they prevented him from fully opening the window. He Parents agreed that this was something that he would have preferred to do. • [redacted] informed the court that her Husband had spoken to Matthew at least four times since their removal and advised against the removal but by the time of death the adaptions had not been re-placed. • In the opinion of [redacted] neither she nor her Husband had notified the Council about the adaptions being removed. • At the conclusion of the inquest I informed [redacted] that I planned to write to her because I had a concern about the risk of future deaths.
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. – • You have a number of tenants. • I was not reassured that the adaptions removed from the window in the flat from which Matthew fell have since been replaced. • Acknowledging that Matthew removed the adaptions himself, and that his reason for so doing was because he preferred to be able to open the window fully, as you advised in court an Inspector had advised that they be put in place and on grounds of safety. • Regardless of whether you and / or your Husband advised Matthew that the adaptions were necessary, Matthew went on to reside in one of your flats for many months during which the window was able to open to the extent it could before the adaptions were added. • There is a concern that if a Tenant of yours is intent on residing in conditions which are at odds with advice you have been given on grounds of the safety of your tenants and no action is taken by you as a Landlord beyond occasionally raising it with the Tenant, then this poses a risk to your current and future tenants.
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 March 2020. 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 Parents of Matthew Willoughby I have also sent a copy to the Chief Executive of Blackpool Council in the event he should 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	19/01/2020 Signature Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**