REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Robert Taylour, Head of Trading Standards, Derbyshire Trading Standards Division, Chatsworth Hall, Chesterfield Road, Matlock, DE4 3FW**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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** I refer to previous correspondence between my office and your [redacted] who helpfully provided some information and a copy of your Investigation Report/ file. By way of background, I initially opened an Investigation on 18 November 2014 into the death of Steven Curtis who was 56 years of age when he sadly died following a workplace accident in Shrivenham, Oxfordshire on 24 October 2014.Mr Curtis had been a patient at Southmead Hospital in Bristol since 1 October which is when he fell from a ladder (the ladder in fact snapped in two) whilst he was using the ladder to inspect a flat felt roof at first floor level. Mr Curtis was a Company Director of his own family roofing business. The ladder was a 3.75m telescopic ladder and it is thought that he fell a distance of about 8 feet. Despite treatment, he subsequently succumbed to the injuries sustained in the fall. The medical cause of death was Ischaemic Heart Disease, Pneumonia and Fracture Ribs (joint causes of death). The Inquest was a jury Inquest due to the fact that the injury was sustained in the workplace. Having said that, it is not a case which the Health and Safety Executive deemed it necessary to investigate despite the fact that my office notified the HSE about the case. I believe that the reason for not investigating was because the HSE were of the opinion that this was a natural cause of death. I do not think that this is correct. The Inquest was concluded on 8 June 2015 at Oxford Coroner's Court. A copy of the Record of Inquest completed by the Jury is attached. It will be seen that the Jury gave a conclusion of "Accident" and made the following findings: *Snapped ladder led to a fall onto a hard surface at Lilac Cottage, 19 Manor Lane, Shrivenham. This caused fractured ribs resulting in lung damage which led to pneumonia and death as a result of Ischaemic Heart Disease. Death occurred on 24 October 2014 at Southmead Hospital, Westbury-On-Trym, Bristol.* In addition to the family, the other "Interested Person" for the purposes of the Inquest was Maplin Electronics Limited. The reason for this is the fact that the family of Mr Curtis believe that the ladder which snapped was one of two telescopic ladders purchased from the Maplin Store at Swindon on 23 April 2014 by the deceased accompanied by his son, Paul Curtis. There was a receipt and sales voucher (copies attached) which confirm that Mr Curtis purchased two N19KJ 3.75 metre Telescopic Ladders from the Swindon store on 23 April 2014. The ladders cost £79.99 each. The evidence from Mr Curtis' family, particularly his sons who worked in the business with him, is that it is one of these ladders which snapped while Mr Curtis was ascending it. The family say that these

	were the only two telescopic ladders used in the business. The ladder which snapped was retained and was inspected as part of the evidence during the Inquest. The second ladder that was purchased at the same time was disposed of after the incident on 1 October - before the seriousness of the injury to Mr Curtis became apparent – so as to avoid anyone else using the ladder and suffering a similar accident. Maplin are of the view however that the ladder involved in the accident is not one of the two ladders that they supplied in April 2014. It is similar but there are material differences. There was evidence produced on behalf of Maplin to substantiate this. On the face of it, there was conflicting evidence which it was not possible to get to the bottom of at Inquest. In any event, I was mindful that establishing the origin of the ladder was probably something that went beyond the scope of the Inquest which is limited to finding the answers to what are called the four statutory questions (how, when and where the death occurred and the identity of the deceased). The family genuinely believe and assert that the ladder came from Maplin. On the other hand, Maplin have produced fairly persuasive evidence that it is not one of their ladders (not one of their ladders with the code N19KJ). Maplin have produced evidence about other persons who purchased the N19KJ ladder from the Swindon store at about the same time as Mr Curtis but these people have not been contacted as part of the Inquest process. It would perhaps be possible to contact them and arrange examinations of the ladders which they purchased to see if the ladders conform to the N19KJ specification/ photographs supplied by Maplin or whether there are differences and they are in fact similar to the accident ladder. It remains to be seen whether it will be possible to carry out any further enquiries to determine whether the accident ladder originated from Maplin or not. I respectfully suggest this is a matter for you to decide.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are briefly set out in the Record of Inquest. It will be seen that Mr Curtis fell from the ladder and was then admitted to Southmead Hospital in Bristol by ambulance. He underwent treatment but there were complications leading to his deterioration and subsequent death.
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 **IF** it transpires that the accident ladder originated from Maplin after all. In the circumstances it is my statutory duty to make this report to you. I said at the Inquest that I would adopt a two-stage approach. Firstly, that I would write to Derbyshire Trading Standards in view of the existing investigation concerning the Maplin N19KJ telescopic ladder. I refer to the letter from Graham Morgan dated 1 June 2015 and the Investigation Report. I see that there was a primary offence in relation to the safety of the ladder and two ancillary offences which led to a caution. The ladders were withdrawn from sale by Maplin. However, I understand that Maplin sold approximately 43,000 of the ladders in the UK before withdrawal. The matter of concern is in relation to the safety of these ladders if it transpires that the accident ladder was supplied by Maplin. To be fair to Maplin, it appears on the existing evidence that there are no other reported cases of catastrophic failures such as this with the N19KJ ladder. The first stage of my two stage process is to enquire if any further investigations can be undertaken by Trading Standards as to the origin of the accident ladder and whether it came from Maplin. I would welcome comments and a response. Relevant copies of the Inquest file are attached.

	The second stage, is a Regulation 28 letter to the CEO of Maplin Electronics Limited to request a review if evidence comes forward suggesting that the accident ladder may have been supplied by Maplin. To this end, I attach a copy of my Regulation 28 Report to Maplin.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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. I may extend the period on request. 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 Interested Persons, including Mr Curtis' family. The Chief Coroner may publish my report and your response 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Tuesday 23 June 2015** **Mr D. M Salter – HM Senior Coroner**