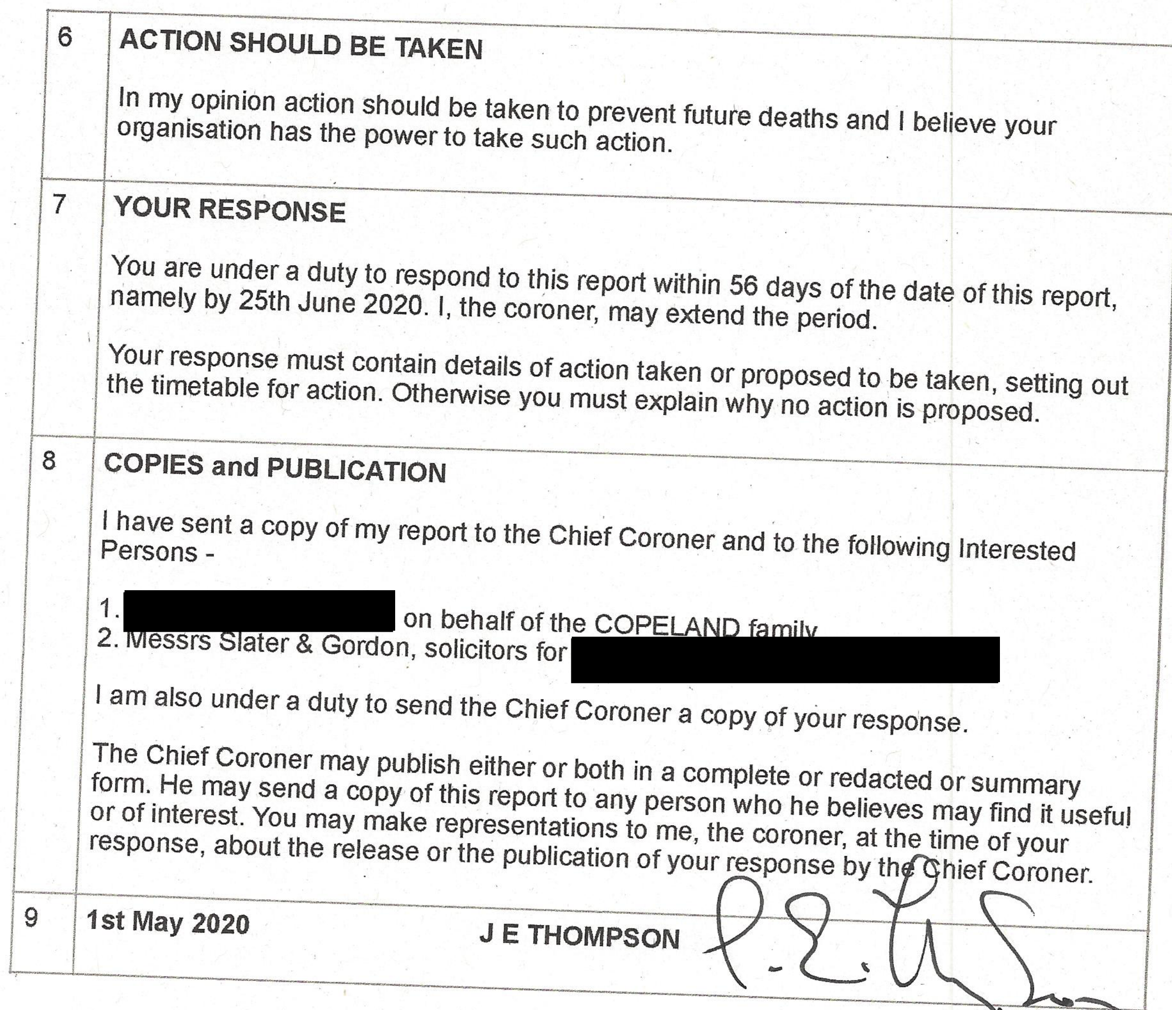
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Operating Officer, TUI UK & Ireland, Wigmore House, Wigmore Pace, Wigmore, Luton, Beds, LU2 9TN**
1	**CORONER** I am James E THOMPSON, assistant coroner, for the coroner area of County Durham & Darlington
2	**CORONER'S 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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 5th October 2018 I commenced an investigation into the death of Barrie Crawford COPELAND, 79. The investigation concluded at the end of the inquest on 27th April 2020. The conclusion of the inquest was Accident. Medical cause of death; 1a. Aspiration pneumonia 1b. Acute intracerebral haemorrhage 1c. Accidental trauma while on anticoagulation for atrial fibrillation 2. Ischemic heart disease & atrial fibrillation A copy of the Record Of Inquest is attached to this report.
4	**CIRCUMSTANCES OF THE DEATH** Mr Copeland was a passenger on board the Marella Discovery (operated by TUI) on 23rd August 2018 whilst in the Broadway Show Lounge on the ship looking for a seat to watch an entertainment event, he fell down a step/s, suffering a head injury which ultimately led to his death on 21st September 2018.
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. – During the course of the evidence heard at the inquest, a witness described the step/s Mr COPELAND fell on were covered in carpet so as to make them difficult to recognise them as steps, and difficult to differentiate the change in the floor level at the venue. The lighting in the lounge can be altered and were not at the time of the accident fully lit. The step/s therefore could be the cause of future accidents. This is of particularly relevance to the infirm and/or those persons with poor eyesight. The inquest did not have any evidence to indicate whether the scene of the accident had been examined by TUI.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25th June 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 - 1. on behalf of the COPELAND family 2. Messrs Slater & Gordon, solicitors for 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	**1st May 2020** **J E THOMPSON**