

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Carrington Doors, Horton Street, Higher Hillgate, Stockport, SK1 3LR</p>
1	<p>CORONER</p> <p>I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and Central)</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12th of march 2012 I commenced an investigation into the death of ALAN SMITH then aged sixty four. The investigation concluded at the end of the inquest on 1st of August 2013. The conclusion of the inquest was Accidental Death, the medical cause of death being Severe Traumatic Brain Injury.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <ol style="list-style-type: none">1. The Deceased, in the course of his employment, attended at DRB Deeside Industrial Estate, Flintshire to repair a factory door.2. In the course of his work he had climbed up a ladder which he had placed against the door which then moved, resulting in the ladder and the Deceased falling to the ground.3. As a result of this fall, the Deceased sustained a severe head injury which caused his death.
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>A witness and co-worker of the Deceased indicated that he had had not received any specific training regarding working at height during the time of his employment at Carrington Doors and indicated that although generic Risk Assessment forms and Method Statements were available, these were not used routinely by employees.</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th of September 2013. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Person [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>[DATE] 5th August 2013 [SIGNED BY CORONER]</p>