REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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THIS REPORT IS BEING SENT TO: 2. HHJ P Thornton, Chief Coroner 3. Publican of The Stockton Public House, High Street, Redcar 1 CORONER I am Clare BAILEY, acting senior coroner, for the coroner area of Teesside. CORONER'S LEGAL POWERS 2 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 7th March 2014 I commenced an investigation into the death of Charles Ronald Hardiman, aged 78 years. The investigation concluded at the end of the inquest on 7th March 2014. The conclusion of the inquest was ACCIDENT with Mr Hardiman having died from head and chest injuries. CIRCUMSTANCES OF THE DEATH 4 On 26th February 2014 Mr Hardiman and a friend arrived at The Stockton Public House at around 11.45am and consumed two and a half pints of beer. Both gentlemen moved to the rear of the premises to smoke a cigarette. They positioned themselves on the top of a platform situated at the top of a flight of five steps. The friend opened the back door to re-enter the premises and a gust of wind took over the door, creating a wind tunnel, causing the door to move forcibly and suddenly pushing Mr Hardiman backwards. Mr Hardiman fell down the stairs and sustained the injuries which resulted in his 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. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. -(1) It was reported that the front door to the Public House was open and created a wind tunnel when the back door was open. This forced the back door to move forcibly and suddenly resulting in the accident. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you AND/OR the owners of The Stockton Public House 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 29 th July. I, the acting senior 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 – who may 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	[DATE] 9 th June 2014 [SIGNED-BY CORONER]
	Quedo
	Clare BAILEY
	Clare BAILEY