### ANNEX A

# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

NOTE: This form is to be used **after** an inquest.

# **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

1. Chairman of the Royal Society for the Prevention of Accidents, Birmingham

### 1. CORONER

I am Professor **Paul MARKS**, senior coroner, for the coroner area of Kingston upon Hull and the East Riding of Yorkshire

### 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. [HYPERLINKS]

## 3. INVESTIGATION and INQUEST

On 9<sup>th</sup> of August 2013 I commenced an investigation into the death of **William PIERCY** otherwise known as Billy PIERCY, aged 52 years The investigation concluded at the end of the inquest on 3<sup>rd</sup> April 2014. The conclusion of the inquest was a **Road Traffice Collision** and the medical cause of death at Ia) Pneumonia Ib) Blunt force neck injury II) Downs syndrome with congenital heart disease.

# 4. CIRCUMSTANCES OF THE DEATH

William PIERCY otherwise known as Billy died on the 25<sup>th</sup> of July 2013 at Hull Royal Infirmary, Anlaby Road, Kingston upon Hull. He died from pneumonia as a result of an injury sustained during a road traffic collision which occurred on the 21<sup>st</sup> of July 2013.

## 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. -

## [BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) Seat belt was disengaged thereby allowing a passenger to be unrestrained and when vehicle came to an abrupt halt, he was thrown forward and fractured his neck. A seat belt alarm would have alerted his carers to the disengagement of the seat belt.

# **ACTION SHOULD BE TAKEN** 6. In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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, namely by [DATE]. 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, His Hon. Judge Peter Thornton QC, and to the following Interested Persons:-Messrs. Capsticks Solicitors, Leeds Claims & Legal Services Department, Hull Royal Infirmary I have also sent it to :-Ministry of Justice, London Sunderland Civic Centre 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

SIGNED BY ?

Professor Paul MARKS Senior Coroner

Coroner.

16 May 2014

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