REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Brandon Lewis MP, Department for Communities and Local Government, 2 Marsham Street, Westminster, LONDON SW1P 4DF CORONER I am Donald Coutts-Wood assistant coroner, for the coroner area of Leicester City and South Leicestershire 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. **INVESTIGATION and INQUEST** On 12th July 2012 I commenced an investigation into the death of Wade Dayabhai Patel, aged 26 years. The investigation concluded at the end of the inquest on 8th October, 2014. The conclusion of the inquest was a narrative conclusion which indicated there was insufficient evidence to ascertain the circumstances of how he came to fall through a glass door at his home address, where he lived with his sister - the tenant of the property. The medical cause of death was: 1a Haemorrhage from incised wounds to the back of both legs. CIRCUMSTANCES OF THE DEATH Mr Patel was found in the hallway of the address, lying close to an inner door that he had fallen through. The glass from that door had caused the injuries to his legs, these injuries leading to death. 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. -The glass in the door is likely to have been the original glass, the property having been built in the 1930's. For obvious reasons the glass did not comply, from a safety viewpoint, with current legislation including building regulations. Much of our housing stock will be of similar age, or older than, significant proportion of that stock will be rented. My understanding is that there is no legal requirement for a landlord or letting agent, to look specifically at safety of glass in a property. I further understand, for example, that there is recent legislation that enhances gas safety, requiring regular checking and

recording of the checks by a suitably qualified person. It therefore seems that such glass will only be replaced either in the process of a refurbishment of the property (thereby complying with current building regulations), or when the glass breaks and requires replacement. Clearly, in this case, the breakage of the glass resulted in the death of Mr Wade Patel. 6 **ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th December 2014. I, the Assistant 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. **COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested (Parents); Leicestershire Constabulary. I have also sent it Environmental Health Officer at Leicester City Council 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