

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Q-Park Limited2. Sheffield City Council (Planning)
1	<p>CORONER</p> <p>I am Donald Stewart Coutts-Wood, assistant coroner, for the coroner area of South Yorkshire (West).</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> <p>(1) Where –</p> <p>(a) A senior coroner has been conducting an investigation under this Part into a person's death</p> <p>(b) Anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and</p> <p>(c) In the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.</p> <p>(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.</p> <p>(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner</p>
	<p>INVESTIGATION and INQUEST</p> <p>On 8th May 2012 I commenced an investigation into the death of Ahmad Doumani Khan (aged 20 years). The investigation concluded at the end of the inquest on 21st January 2013. The conclusion of the inquest was that Mr. Khan died from multiple injuries sustained in a fall from the top level of the Q Park car park, St. Paul's Square, Sheffield. The narrative conclusion stated that no other person was directly involved in the fall, but it was also not clear if Mr. Khan intended to take his own life.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the morning of the 3rd May 2012 Mr. Khan was in Sheffield city centre, with friends. Mr Khan was known to have problems, and he sent text messages to persons at that time. However, he was also indicating plans he had for later that day, and into the</p>

	<p>future.</p> <p>CCTV shows that Mr. Khan and a friend were in the area of the Q Park car park from 1300 hours to 1710 hours on that date. They were seen to walk up through the lift area of the car park and eventually they went onto the top floor, which is uncovered. There is no CCTV coverage of the area where Mr. Khan fell from.</p> <p>Mr. Khan was with his friend when he got on to the perimeter wall, near to a corner of the car park. A short while later he fell, witnessed both by his friend and a person in a nearby building. Mr. Khan's friend indicated that when he, Mr. Khan, was stood on the perimeter wall, at the corner, Mr. Khan was only about 3 feet above him.</p>
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>(1) Access to the perimeter wall is very easy. There is the height issue (only about 3 feet), but also the fact that inside the wall is a crash/protective barrier for the parking of cars, which was described by the friend as being used by Mr. Khan as a 'step', up on to the wall. The concern is that any person, of almost any age, and certainly much younger than Mr. Khan, could quickly and easily gain access to the top of the perimeter wall for any purpose. Such access is clearly dangerous.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have 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 28th August 2014. 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 Persons: The family of Mr. Khan.</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>
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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.

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[DATE] 28 JUNE 2014

[SIGNED BY CORONER]

