IN THE WEST YORKSHIRE WESTERN CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Steven Bottomley A RegulationReport – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

1 | CORONER

Martin Fleming HM Senior Coroner for West Yorkshire Western

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 20 of the Coroners (Investigations) Regulations 2013

3 INVESTIGATION and INQUEST

On 6/11/14I opened an inquest into the death of **Steven Bottomley**who, at the date of his death was aged 44 years old. The inquest was resumed and concluded on 28/4/15

I found that the cause of death to be: -

1a. Chest and abdominal injuries

I concluded with a finding of accidental death.

4 | CIRCUMSTANCES OF THE DEATH

At approximately 6.12 am on 1/11/14 Steven Bottomley was found collapsed and unresponsive on the cobbled courtyard at the rear of 60 Keighley Road. Upon the arrival of paramedics he was found to have died. Upon the arrival of the police it was found that he had fallen from the open window of his flat 7, 60 Keighley Road. The window was approximately 3-4ft in height and approximately 2-3ft wide and opened outwards being hinged at the top. The window ledge was positioned approximately two feet from the flat floor, and was not fitted with any safety measures. It was found that he had an unwitnessed fall out of the window whilst under the influence of drugs and alcohol.

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5 CORONER'S CONCERNS

During the course of the inquest I heard that the window was not fitted with a safety device

The MATTER OF CONCERNisas follows. -

- To review the safety of the window
- To take necessary remedial action to safeguard the window along with all like windows in the properties in accord with authorised building regulations in order to prevent a recurrence.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 COPIES

I have sent a copy of this report to:

- •
- Chief Coroner

9 **DATED this 14/5/15**

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