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. Radcliffe Investment Properties Limited, Molteno House, 302 Regents Park Road, London, N3 2JX**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (Eastern)
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.
3	**INVESTIGATION and INQUEST** On 2nd June 2017 I commenced an investigation into the death of Marcus Anthony Allen, aged 32. The investigation concluded at the end of the Inquest on 8th May 2018. The conclusion of the Inquest was a Narrative Conclusion that he sustained fatal head injuries when he fell from a window at his home at 34 Whingate Mills Flats, Armley, Leeds on 1st June 2017.
4	**CIRCUMSTANCES OF THE DEATH** On 1st June 2017 at approximately 2215 hours neighbours heard a noise and on looking out of their windows saw the motionless body of a man lying beneath the open window of [redacted] The Emergency Services attended and pronounced the man, later identified as Marcus Anthony Allen, dead at 2255 hours on 1st June 2017 at the car park of Whingate Mills Flats, Armley, Leeds. Mr Allen was known to use the drug, Ketamine. Toxicology analysis revealed he had consumed Ketamine at a level known to cause confusion, loss of coordination, psychological disassociation and hallucinations. A Police investigation concluded that Mr Allen had fallen from the lounge window of his flat on the second floor. No devices restricting the opening of the large window were fitted. The circumstances in which he came to fall are unclear as is his intention at that time.
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) The large window in the lounge of flat [redacted] has no restrictor device fitted. In consequence it can open to a position which necessitated a person leaning out of the window in order to close it. This was considered by witnesses to create a hazard involving a risk that a person may fall when attempting to close the window. It may be that other windows in the flat complex also have the same potential hazard.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 10th July 2018. 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 and to the following Interested Persons: The family of Marcus Anthony Allen. I have also sent it to West Yorkshire Police, F.A.O. [redacted] and Leeds Council (Private Sector Housing Manager, [redacted] 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] 11th May 2018** **[SIGNED BY CORONER]** Kevin McLoughlin **Kevin McLoughlin, Senior Coroner**