Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 British Standards Institution, 389 Chiswick High Road, London, W4 4AL (cservices@bsigroup.com)

1 CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 13 September 2018 I commenced an investigation into the death of Ava-May LITTLEBOY aged 3 years. The investigation concluded at the end of the inquest, held with a jury, on 19 March 2020. The medical cause of death was:
1a Traumatic Head Injury
The conclusion of the inquest was: Ava-May's guardians paid for the use of a trampoline which exploded following which she died

4 CIRCUMSTANCES OF THE DEATH

Ava-May went to the beach at Gorleston with her family on 1 July 2018. She went on an inflatable trampoline, which exploded, throwing her into the air. She died later that day in James Paget University Hospital as a result of her injuries.
Questions for the Jury:
1a) When acquiring the inflatable trampoline was an operating/Instruction Manual relevant to the trampoline obtained? NO
b) Was the trampoline checked by an independent third party before its use? NO
2. Was there an up to date and complete Risk Assessment in respect of the trampoline as at 1 July 2018? NO
3. Was a procedure in place to safely manage the inflation of the trampoline (even when the site was open to customers)? NO
4a) Did staff receive training in respect of working with the equipment and customers on site? SOME
b) Did staff receive training in respect of operating the trampoline? NO
5a) Were staff supervised whilst working on site? SOME OF THE TIME
b) Were children supervised by staff when going onto the trampoline SOME OF THE 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. Evidence was heard that it is required a device will be inspected by an independent third party and, provided it satisfies relevant requirements, it will be certified under the Amusement Device Inspection Procedures Scheme (ADIPS) (or Pertexa Inflatable Play Equipment (PIPA) or another testing scheme or method which demonstrates how such procedures equal or better the accepted best practice) as safe to operate and a Declaration of Operational Compliance (DOC) will be issued. If the device is not deemed fit to use, then the device is categorised according to the defect or concern raised which may result in a DOC not being issued and the operator advised not to use the equipment until the defect has been rectified.
   The inflatable trampoline had been acquired in August/September 2017 and was inspected by an independent company on 26 June 2018 (namely 4 days prior to the trampoline exploding). Concerns

were raised by the independent company with regard to no pre-use manufacturing paperwork being available and that not all Tie Downs were being used. Evidence was heard that had the trampoline been registered under ADIPS a Category A defect would apply, namely that the device is considered as being of imminent danger to persons and that the device should not be used until those defects have been rectified. As such, a DOC would not have been issued and it would have been clear that the trampoline was not fit to be used.

However, as the trampoline had not been registered under ADIPS (or PIPA or an independent scheme), the issues could not be categorised and it would not be recorded in any public domain that a DOC had not been issued.

2. Further, there is no requirement that the relevant enforcing authority, for instance Health and Safety Executive or the Local Authority is informed that the equipment is deemed unsafe to use.
3. The evidence also revealed that there is no legal requirement for an Operator to use either the ADIPS or PIPA inspection process but can rely on an alternative form of scheme or method of their own choosing to demonstrate the device is safe to use.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 28 May 2020. 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:
[redacted] and [redacted]
Great Yarmouth Borough Council
Health and Safety Executive

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 Dated: 02/04/2020

Jacqueline LAKE
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