REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **RH Thomas Pursglove MP** **Minister of State for Disabled People, Health and Work.** **House of Commons** **London** **SW1A 0AA** **RH Nusrat Ghani MP** **Minister of State for Business, Energy and Industrial Strategy** **House of Commons** **London** **SW1A 0AA**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 9th December 2021 I commenced an investigation into the tragic death of- **Sylvia Frances PRICE** The investigation concluded at the end of the inquest on 8th December 2022. The conclusion of the inquest was that:- **Sylvia Price, died as the result of an accidental death** The medical cause of death was confirmed as: **1a Aspiration pneumonia** **1b Intracerebral, subdural and extradural haemorrhages** **2 Cervical and thoracic spine fractures**
4	**CIRCUMSTANCES OF THE DEATH** **Sylvia Frances Price died on the 4th December 2021 at 0915 am, at Ipswich Hospital, Heath Road, Ipswich.** **Sylvia attended Ufford Park Hotel and Spa on the 30th November 2021 for a meal. Prior to leaving the hotel, Sylvia went to use the toilet facilities. The closest toilet facilities were located down a flight of stairs. Sylvia fell down this flight of stairs.** **No signage was in place in the vicinity, that would have indicated the availability of an accessible toilet on the same level as an alternative option.**

	The injuries she sustained as a result of the fall were extensive, and led to Sylvia being admitted to Ipswich Hospital. Whilst being treated for her injuries at Ipswich Hospital, Sylvia developed aspiration pneumonia which was the medical cause of her death. **The injuries sustained in the fall, cerebral haemorrhages and spinal injuries, were contributing factors to her death.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – **Evidence was heard that Sylvia had underlying medical issues that required an easily accessible toilet facility.** **The jury concluded that the lack of appropriate signage, to readily identify an easily accessible toilet facility, was a directly contributory factor leading to Sylvia's death.** **The Local Authority Food and Safety Officer who investigated this case identified no other contributing factors, with the stairs themselves meeting building and safety regulations.** **The officers report contained only one recommendation for the premises owner, which was the provision of more adequate signage.** **However, the officer stated in evidence that there was no statutory power to enforce the provision of such signage, and should a premises owner wish to ignore such a recommendation, they could (it is acknowledged that the premise owner in this case has put new signage in place). In addition, current building regulations do not require any such signage to be fitted into new buildings.** **The court was informed that the provision of adequate accessible toilet facilities is now a legal requirement for the majority of buildings designed for public use, but as detailed above there is no requirement for these facilities to be clearly identified with appropriate signage.** **As a failure to provide adequate signage was found to be a contributing factor in this case, and there is no enforceable requirement that such signage should be provided, I am concerned further deaths may occur in other public access buildings, should similar circumstances arise in the future.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd March 2023 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. Sylvia's next of kin. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**4th January 2022** **Nigel Parsley**