Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Association of Conservative Clubs LTD** **1 Norfolk Row** **London** **SE1 7JP**
1	**CORONER** I am M D FLEMING, HM Senior Coroner for the coroner area of West Yorkshire Western Coroner Area
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 22/3/22 I opened an inquest into the death of Stephen Geoffrey Preston who, at the date of his death was aged 68 years old. The inquest was resumed and concluded on 7/2/23 I found that the cause of death to be: - 1a Haemorrhage from face and neck injuries II Hypertensive Heart Disease I arrived at a conclusion of Accident.
4	**CIRCUMSTANCES OF THE DEATH** I heard that Mr Stephen Preston had previously served the Earlsheaton Conservative Club in Dewsbury for many years in the capacity as Secretary and Trustee. On 6/5/22 Stephen was in the company of several friends in the Club whilst he was overseeing in a voluntary capacity the entertainment that had been previously booked to appear. During the afternoon he had been drinking alcohol, although he was not thought to be unduly intoxicated when he left the club for a taxi to take him home. It was as Stephen made his way down the stairs, with the assistance of a walking stick, that he took a fall on the lower steps, causing his head to make direct contact with the glazing in the double doors at the bottom of the stair case, such that his head became lodged between the broken glass. Although paramedics arrived very quickly, Stephen was found to have passed away. In considering the evidence, I noted the contents of an experts' report who had conducted a site visit at the club, in which he expressed the view that the glazing that Stephen made contact with was not safety glass and as such was a major contributor to his demise. He also confirmed that the double doors were too near the bottom step and do not comply with legislation governing the spatial requirements. During the inquest representatives of the Club informed me that they were to immediately take remedial steps to prevent a further recurrence and that they would write to me in due course to confirm that they have been implemented.
5	**CORONER'S CONCERNS**

	It became clear during the inquest that the double doors and glazing had been installed in the early 1990's and not in accordance with current H&S requirements. The **MATTERS OF CONCERN** are as follows: - To review and consider the adequacy of such glazing in doors positioned at the bottom of the stairs, throughout other Conservative Clubs in England and Wales to enable compliance with existing H&S and Fire regulations. - To review and consider the adequacy of the proximity of the doors positioned near to the bottom of the stairs throughout other conservative Clubs in England and Wales in order to ensure compliance with existing H&S and Fire regulations.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe The Conservative Association 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 April 11, 2023. 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]**- Daughter** **Earlsheaton Conservative CLUB** [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 14/02/2023** M D Fleming **M D FLEMING** **HM Senior Coroner for** **West Yorkshire Western Coroner Area**