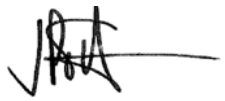
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Health & Safety Manager The Range Elsie Margaret House William Prance Road Plymouth PL6 5ZD
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
2	**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 the 25th April 2023 I commenced an investigation into the death of John Neil SHENTON. The investigation concluded at the end of the inquest on the 1st of August 2023 with a conclusion of Accidental Death. The medical cause of death was Ia) Bronchopneumonia Ib) Fractured Ribs and II) Chronic Obstructive Pulmonary Disease, Type II Diabetes Mellitus
4	**CIRCUMSTANCES OF THE DEATH** On the 17th April 2023 Mr Shenton, together with his wife and son, went to the The Range, Forge Retail Park, Telford TF3 4PB. Mr Shenton was 82 years of age with limited mobility and was to that extent vulnerable. They initially tried to use the lift in the store but it was not in operation. They went to the first floor by escalator and subsequently Mr Shenton fell stepping on the descending escalator. Mr Shenton sustained injury and sadly as a result died 4 days later at the Princess Royal Hospital, Telford on the 21st April 2023. The circumstances of the accident were investigated and are set out in a report from [redacted] Telford & Wrekin Council Environmental Health Officer.
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) At the inquest you not aware of the report and the recommendations/action required as set out in paragraphs 5.1 to 5.8. (2) Those actions remain outstanding and should be addressed. (3) Essentially whilst the descending escalator was fit safe for a non-vulnerable person more should be done to protect a vulnerable person, particularly if they have to use the escalator when the lift is not in operation.

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 27th September 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. I have also sent it to [redacted], son of the deceased on behalf of the family. 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	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 2nd August 2023