

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 Acis HOUSING
1	CORONER
	I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 12 September 2023 I commenced an investigation into the death of Frederick POWELL aged 93. The investigation concluded at the end of the inquest on 24 October 2023. The conclusion of the inquest was that:
	The deceased died on 6th September 2023 at 20 St.Martins Close, Blyton , Gainsborough when he fell through a glass door at home suffering life threatening injuries that he failed to recover from.
4	CIRCUMSTANCES OF THE DEATH
	The deceased died on 6th September 2023 at 20 St.Martins Close, Blyton , Gainsborough when he fell through a glass door at home suffering life threatening injuries that he failed to recover from.
5	CORONER'S CONCERNS
	During the course of the investigation my inquiries revealed matters giving 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 are as follows: (brief summary of matters of concern)
	Although it is not suggested current building regulations were breached the Inquest was told many more properties in your stock retained internal glass doors. Is it time for a review to reconsider replacement ?
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 December 19, 2023. I, the coroner, may extend the period.

