# Regulation 28: Prevention of Future Deaths report

**Bernadette Grace FAULKNER (died 8 December 2022)**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Lee Rowley MP**<br>**Minister of State for Housing, Planning and Building Safety**<br>**The Department for Levelling Up, Housing & Communities**<br>**2 Marsham Street**<br>**London**<br>**SW1P 4DF**<br><br>**2. [redacted]**<br>**Chief Executive**<br>**Energy UK**<br>**26 Finsbury Square (4th Floor)**<br>**London**<br>**EC2A 1DS** |
| 1 | **CORONER**<br><br>I am Ian Potter, assistant coroner, for the coroner area of Inner North London. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 13 December 2022, an investigation was commenced into the death of BERNADETTE GRACE FAULKNER, then aged 80 years. The investigation concluded at the end of an inquest, heard by me, on 13 December 2023.<br><br>The conclusion of the inquest was accidental death, the medical cause of death being:<br><br>1a respiratory failure<br>1b lung contusion<br>1c multiple bilateral rib fractures (out of hospital fall, 2/12/2022)<br>II obstructive sleep apnoea, type 2 diabetes mellitus, hypertension, asthma |
| 4 | **CIRCUMSTANCES OF THE DEATH** |

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| | (1) Mrs Faulkner rented a flat from her local authority, which was a former Victorian townhouse converted into four separate flats. Her electricity meter (installed in 2001) was in a cupboard, just inside the communal door to the flats, some 7-8 feet off the ground.<br><br>(2) Mrs Faulkner, was only 4'10" tall, and had no choice but to access the meter using a stepladder every time she wished to add credit to her pre-payment meter.<br><br>(3) On 2 December 2022, Mrs Faulkner purchased credit for her electricity meter and then climbed the stepladder to put the credit onto the meter. In trying to access the meter she fell from the ladder and landed on the floor, where she was discovered some hours later by neighbours.<br><br>(4) Mrs Faulkner sadly died in hospital on 8 December 2022, as a direct result of the injuries she sustained in the fall. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence 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.<br><br>The **MATTERS OF CONCERN** are as follows:-<br><br>(1) The electricity meter was installed at such a height that anyone wishing to access it would be unable to do so without the use of steps/a ladder. In addition, the placement of the meter (immediately behind an inwardly opening front door with no windows) added to the risk of using a stepladder because anyone coming through the door would be entirely unable to see anyone using a stepladder behind the door. Irrespective of the type of meter, it is reasonably foreseeable that electricity meters need to be accessed by people from time to time and not only those with the requisite training for working at height.<br><br>(2) Siting prepayment meters, in particular, at such a height and location adds to the risk, because those choosing to use a pre-payment meter are required to access it each and every time they top-up the meter.<br><br>(3) The electricity company which installed the meter in 2001 has "no records of what consideration they gave at the point of installation to the specific meter location." Other meters in the property are at a similar height and it is not uncommon to find electricity meters at heights requiring steps to access them; there appears to be no industry standard requiring electricity meters to be easily accessible (albeit secure) by all potential customers, except perhaps in new build properties. |
| 6 | **ACTION SHOULD BE TAKEN** |

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| | In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 February 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Person:<br><br>(a) [redacted] (Bernadette Faulkner's son).<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **Ian Potter**<br>**HM Assistant Coroner, Inner North London**<br>**4 January 2024** |