ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield City Council**
1	**CORONER** I am Alexandra Pountney, assistant coroner, for the coroner area of South Yorkshire (West District)
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 29 September 2022 an investigation was commenced into the death of Saffra Harriett Winn. An inquest started on 18 March and concluded on 19 March 2024. The cause of death was: 1 (a) Multiple injuries 1 (b) Fall from height
4	**CIRCUMSTANCES OF THE DEATH** At approximately 5.55am on 24 July 2022, Saffra was found on the pavement between two blocks of high-rise flats, known as Martin and Burlington. Emergency services were called, and police and paramedics attended the scene. On arrival, paramedics notes that Saffra was unconscious, was not breathing and had suffered extensive injuries that were beyond medical assistance and were incompatible with life. Life was declared extinct by paramedics at 6.08am. The police conducted an investigation, and saw that the window of Saffra's flat, [redacted], was open above the area where she was found. The

	police concluded that it was likely that Saffra had jumped or fallen from the window of her [redacted] flat [redacted]. The police came to that conclusion for the following reasons: a. CCTV was reviewed from the flats which showed Saffra falling from the building and showed that no person had entered or exited her flat during the relevant times. b. The flat door was locked from the inside, with the key in the lock. c. There were foot/scuff marks on the internal and external window sills. There was no evidence of an intention by Saffra to take her own life. The council did not conduct a post-incident safety inspection of the windows in the flat, beyond the usual post-tenancy inspection. The police found that the safety restrictor on the window had been manually disengaged to allow it to open fully.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTERS OF CONCERN** are as follows. – The inquest heard that there have been two fatalities by tenants falling from this type of window in high-rise buildings in a short period of time between July 2022 and December 2023. Notwithstanding these fatal events, Sheffield City Council has not yet completed any risk assessment of the windows or the safety latches on the windows. A Building Safety Regulator was put in post at the council in January 2023, some 11 months before the second fatality and 6 months after the first, and this person has not been consulted in relation to the safety or risk posed by the windows. I am concerned that this poses a risk of future death. More generally, I am concerned by Sheffield City Council's in action in relation to the investigation and assessment of risk following cases of catastrophic injury and death within their social housing stock. I am concerned that a failure to properly investigate and risk assess any incident of this nature, together with the absence of any formal procedure or policy for this process, poses a risk of future death. There is no evidence before the inquest which alleviates my concern in this respect, in fact the inquest was told that the Head of Housing Investment and Maintenance for the council was not aware of the fatal incidents above until his attendance was required at this inquest.

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 22 May 2024. 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 Interested Persons. 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 other 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.
9	**Alexandra Pountney HMAC 27/03/2024**