Mr Sean McGovern
H M SENIOR CORONER

Mr Delroy Henry
H M AREA CORONER

Coroner's Office

Tel: 02476 975509

Email: [redacted]

Date: 18 July 2025
Our Ref: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Minister of State for Health

2. The Chief Executive of the Health and Safety Executive

3. The Lift and Escalator Industry Association

CORONER

I am Linda Lee, Assistant Coroner for the coroner area of Coventry and Warwickshire.

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.

INVESTIGATION and INQUEST

On 24 October 2024 I commenced an investigation into the death of Jacqueline Mary LANGWORTHY, 61. The investigation concluded at the end of the inquest, heard before a jury,

from 7 July 2025 to 10 July 2025.

The conclusion of the inquest was:

Accident

The cause of death was:

1a

Asphyxiation

1b.

1c .

II .

CIRCUMSTANCES OF THE DEATH

Miss Langworthy was an experienced care assistant who had recently begun employment at a care home, where she was shadowing more senior members of staff. The home was equipped with a platform lift, intended for transporting wheelchair users accompanied by a carer. It was also used to move bulky equipment, although care home policy prohibited staff from travelling in the lift with equipment.

For reasons that remain unclear, Miss Langworthy entered the lift with stand aid. As the lift descended, the wheels of the stand aid caught on the edge of the lift platform, causing it to become wedged and pin Miss Langworthy against the wall of the lift shaft. Although she was able to call for help, Miss Langworthy could not reach the controls. The platform continued to descend, suspending her mid-air.
By the time she was freed, she was unresponsive, and resuscitation was unsuccessful.

An experienced HSE engineer examined the lift and confirmed there were no mechanical defects in either the lift or the stand aid. The engineer found that, once the downward toggle switch had been activated, the platform continued to move under latch control, placing the controls out of Miss Langworthy's reach, as she remained trapped above the platform. The platform could not be stopped via the control wall pressure switch while descending.

The engineer noted that such risks were known within the industry, with a history of wheelchair users being injured in similar circumstances. She explained that "hold-to-run" controls —now a requirement under current standards (BS EN 81-41:2010)—would likely have prevented the incident, as the passenger would be expected to release the control in the event of
danger. However, the lift pre-dated this requirement (BS 6440:1999), and such standards are not applied retrospectively.

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 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. –

(1) Many platform lifts still in use in care settings and other premises do not have hold-to-run controls.

(2) Evidence was received indicating that such controls can be retrofitted at relatively low cost.

(3) There is limited awareness of both the risks posed by the absence of hold-to-run devices and the feasibility of fitting such devices to existing platform lifts.

ACTION SHOULD BE TAKEN
In my opinion action should be taken to prevent future deaths and I believe you and/or your

organization have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 September 2025. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested

Persons: The Food and Safety Team at Coventry City Council
I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner 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.

She 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.

Signature 

Linda Lee

Assistant Coroner

Coventry and

Warwickshire