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 Secretary of State for building safety, fire and construction regulations**
1	**CORONER** I am Helen Rimmer, Area Coroner for the coroner area of Liverpool and the Wirral.
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 17 March 2025 an investigation into the death of Joshua Christopher Edward PERRY aged 21 was commenced. The investigation concluded at the end of the inquest on 02 April 2026. The conclusion of the inquest was that: Cause of death 1a. Multiple Injuries Conclusion Narrative - Joshua died as a consequence of falling from the nineteenth floor of a multi storey car park from which he suffered multiple injuries, which proved fatal. On the evidence it is not clear whether he intended to take his own life.
4	**CIRCUMSTANCES OF THE DEATH** On 14th March 2025, Joshua Perry fell from the 19th floor of the multi storey car park situated on [redacted] horizontal railings at the car park facilitated Josh's fall from height. Police officers attended and located Joshua on the floor between two vehicles in a car park on the junction of [redacted] Cardio pulmonary resuscitation was performed, however Joshua had suffered multiple injuries as a result of the fall and his death was verified by paramedics at 18:31 hours. There were no suspicious circumstances surrounding Joshua's death. Toxicological analysis revealed that Joshua had consumed ketamine prior to his death at a concentration consistent with moderate excessive use, the effects of which can include drowsiness/sedation, intense hallucinations and unsteadiness. In the context of Joshua having consumed ketamine, which more likely than not influenced Joshua's cognitive functioning, it cannot be established on a balance of probabilities that he intended to take his own life.
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:

	During the course of the inquest it came to my attention that there is a conflict between The Building Regulations 2010, Guidance: Approved Document K and BSI Standards, barriers in and about buildings, Code of Practice, which requires resolution and may prevent future deaths. Document K at K2 paragraph 3.2 outlines that guarding must be at a minimum height and that any wall, parapet, balustrade or similar obstruction can be used as guarding. The British Standards, Code of Practice indicates that barriers installed on parapet walls should be measured from the top of the parapet and not at walk level. It is not clear from the guidance and standards where the starting point of the barrier height is to be taken from when a wall, parapet, balustrade or similar obstruction is used as guarding. Document K at K2 paragraph 3.3 outlines that the use of horizontal railings should be avoided to prevent children under the age of 5 years readily being able to climb the guarding, there is no mention of this also being applicable to adults and children over the age of 5 years.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 02, 2026. 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 following Interested Persons [redacted] I have also sent it to **ParkBee Ltd** who may find it useful or of interest. 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 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. They may send a copy of this report to any person who they believe 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	**Dated: 07/04/2026**

	 Helen RIMMER **Area Coroner for** **Liverpool and Wirral**