IN THE WEST YORKSHIRE WESTERN CORONER'S COURT IN THE MATTER OF:

The Inquests Touching the Death of Marko Petrovic A Regulation Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO: Health and Safety Executive 1 **CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western **CORONER'S LEGAL POWERS** 2 I make this report under paragraph 7, Schedule 5, of the coroners and Justice Act 2009 and regulations 28 and 20 of the Coroners (Investigations) Regulations 2013 **INVESTIGATION and INQUEST** I opened an inquest into the death of Marko Petrovic on 19/1/16 who, at the date of his death was aged 53 years old. The inquest was resumed before a jury on 13/11/17 and concluded on 16/11/17 The jury found the cause of death to be: -1a Multiple injuries The jury arrived at a conclusion of Accident. Under Box 3 Marko Petrovic died as a result of multiple injuries resulting from a fall from the roof of a four storey building on 11 January 2016 at Calderdale Royal Hospital. Work commenced before additional barriers were in place. The scaffold was taken down to a point where what was left became unstable. The scaffold fell from the roof and fell to the ground along with Marko. **CIRCUMSTANCES OF DEATH** Mr Petrovic was employed by Talk Scaffold as an advanced scaffolder with many years experience, owned by its Director

which was contracted by RH Fulwood to erect scaffolding on the roof of Calderdale Royal Hospital in Halifax to enable the completion of structural work contracted to them by Cofley Integrated (now known as Engie) who had the responsibility for managing the hospital site.

At 7am 11/1/16 Mr Petrovic and colleague scaffolders,

and

arrived at the hospital to

dismantle the scaffold, which they had previously erected on 18/12/15, after the repairs on the roof, had been completed.

Whilst arrangements were being made to fully cordon off the ground area, Mr Petrovic and colleagues went onto the roof to dismantle the cantilever scaffolding which protruded from the roof, by taking parts to the ground in a service lift in order to place them onto a wagon parked underneath. Evidence was heard to suggest that Mr Petrovic as the most experienced scaffolder made a decision to commence dismantling from a point opposite to the cantilever in order to allow time for the barriers to be fully erected.

As instructed by Mr Petrovic, his colleagues left him on the roof to continue dismantling the scaffold whilst they took the parts to the ground floor in the service lift. It was then that the scaffolding platform became unstable causing it to fall from the roof along with Mr Petrovic who sustained severe injuries. Although he was rushed into A&E, notwithstanding attempts to resuscitate him, he succumbed and died from his injuries

The jury heard expert evidence to suggest that Mr Petrovic had taken the decision to dismantle the scaffolding from the wrong end, which destabilised the remaining platform.

5 CORONER'S CONCERNS

The **MATTER OF CONCERN** is as follows. During the inquest evidence was heard to suggest that there are no written guidelines with respect to the dismantling of cantilevered scaffolds.

 During the inquest evidence was heard to suggest that there are currently no written guidelines with respect to dismantling of cantilevered scaffolds. In this respect I would ask that the consideration be given to a further review of the existing guidelines.

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 Although evidence was heard to suggest that a RAMS had been initiated with respect to the erection of the scaffolding, a further RAMS to cover the subsequent dismantlement of the scaffolding was not required. I would ask that consideration be given to the appropriateness of further RAMS specific to the dismantlement of the scaffolding.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the Health and Safety Executive has the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

8 COPIES

I have sent a copy of this report to:

- Construction Industry Training Board
- Construction Industry Scaffolders Record Scheme
- (partner to Mr Petrovic)
- Talk Access
- RH Fulwood
- Calderdale Hospital SPC Ltd
- Calderdale and Huddersfield NHS Foundation Trust
- Engie
- Chief Coroner
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9 **DATED this 15/9/16**

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