REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Inspector for Health and Safety Executive, Policy Support Construction [redacted]
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 22th and 23th October 2019, evidence was heard touching the death of **Eugeniusz MALEK.** On Saturday 23rd June 2018, Mr Malek was part of a team of plasterers renovating a house. He fell from a ladder sustaining fatal injuries. He was 50 years old at the time of his death. The jury made the following findings: **Medical Cause of Death** I (a) exsanguination (b) Transected Right Femoral Artery (c) Penetrating Injury to Right Groin II Alcohol Intoxication **How, when, where Mr Malek came by his death:** On 23rd June 2018, at [redacted] Mr Eugeniusz Malek fell from a ladder onto a scaffolding pole resulting in the injuries stated above. He was pronounced dead at 09:40. On the balance of probabilities the deceased's alcohol levels contributed to his death. **Conclusion of the Jury as to the death:** Mr Eugeniusz Malek died as a result of an accident.
4	Extensive evidence was taken in court. In summary, of relevance to this report: The pole on which Mr Malek landed was uncapped and therefore sharp edged and more likely to inflict the injuries sustained. There is no current regulation that uncapped scaffolding poles in areas where a person may fall, walk into, or trip over them should be capped. Some building sites voluntarily cap such poles, or otherwise pad them. Caps are relatively cheap and easily available.

5	**Concerns of the Coroner:** 1. That ends of scaffolding poles sited in areas where workers may fall, trip or collide with them should be capped.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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. 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], Levenes Solicitors. By email: [redacted] 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. 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	**17th December 2019** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**