

# East London Coroners MISS N PERSAUD SENIOR CORONER

## Walthamstow Coroner's Court, Queens Road, Walthamstow, E17 8QP Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

4<sup>th</sup> March 2020 REF: 9925

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Tradomi S.L., Camino Viejo, 0, 30890, Puerto
	Lumbreras, Murcia, Spain Sent via email to:
1	CORONER
	I am Miss N Persaud Senior Coroner for <b>East London</b>
	Tail Miss N Persaud Semor Coroner for East Longon
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.
	http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
	http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	Following an Inquest which was opened on the 18 <sup>th</sup> January 2019 the investigation concluded on the 3 <sup>rd</sup>
	March 2020. The conclusion of the Inquest was a narrative conclusion:
	Mr Sanchez-Figueroa died from a traumatic brain injury caused by a fall from the back of his lorry. The
	absence of secure footing and leveraging contributed to the accident.
4	CIRCUMSTANCES OF THE DEATH
	Mr Sanchez-Figueroa worked as a long distance lorry driver. He had delivered a load of vegetables to the
	New Spitalfields Market in Leyton, London on the 17 December 2018. At around 20:00 hours on the 17 <sup>th</sup> December 2018 he was found unconscious near to his lorry with a severe head injury. The
	circumstances in which he was found indicated a likely fall from the back of his trailer. A metal prop/stay
	that should have been secured in the back of the trailer was found on the ground with blood staining on
	it. Investigators from the Metropolitan Police Service and the Health and Safety Executive considered
	that the mechanism of injury was most likely to have been fall from the back of the lorry in which the stay/prop was likely to have been involved. It was noted during the course of the Inquest that there was
	no hand hold to assist drivers to enter their trailers. It was further noted that drivers would be
	responsible for stowaways and may need to check the interior of their trailer. Sadly, Mr Sanchez-
	Figueroa died from his injury's at the Royal London Hospital on the 23 <sup>rd</sup> December 2018.
5	CORONER'S CONCERNS
	The MATTERS OF CONCERN DURING THE COURSE OF THE INQUEST are as follows. ~

There appeared to be no hand hold/grab rail to assist drivers in pulling themselves up into the interior of their trailers. The metal prop/stay is not designed to be used for this purpose. As there is nothing purpose built to assist drivers to pull themselves up, it would be very tempting for drivers to use the prop/stay for this purpose.

In addition, there were no items within the lorry that would have assisted Mr Sanchez-Figueroa to carry out the checks required from the Border Force Agency. Carbon-dioxide detectors or telescopic mirrors could assist drivers with these checks and none of these items were present within the vehicle.

#### 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. **7** May 2020 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, to the solicitor acting on behalf of the family and to the Health & Safety Executive.

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.

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Signature

Miss N Persaud Senior Coroner East London