

## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p><b>Priti Patel MP, Secretary of State for the Home Department</b></p>
1	<p>CORONER</p> <p>I am Chris Morris, Area Coroner for Manchester South.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p><a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 16<sup>th</sup> November 2020, I opened an inquest into the death of Emiel Ariel Malinski who died on 2<sup>nd</sup> November 2020 at Salford Royal Hospital, aged 29 years. The investigation concluded at the end of the inquest which I heard on 8<sup>th</sup> June 2021.</p> <p>A doctor treating Mr Malinski confirmed that he had died as a consequence of:</p> <p>1)a) Traumatic brain injury; due to 1)b) Gun shot injury to the head.</p> <p>By way of conclusion, I recorded that Mr Malinski died as a consequence of suicide.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Malinski was an air-rifle owner who used to frequent a shooting range at Weir Mill, Moseley, Tameside. The range in question constitutes a 'Miniature Rifle Range' for the purposes of s11 (4) Firearms Act 1968.</p> <p>On 2<sup>nd</sup> November 2020, Mr Malinski attended the range with his air-rifle. Later in the day, Mr Malinski was loaned a semi-automatic Hammerli Tac1 22 rim fire rifle to shoot, and supplied with 50 rounds of 0.22 calibre ammunition.</p> <p>Whilst alone on the range, Mr Malinski turned the rifle on himself and fired a shot in the direction of his right temple. Mr Malinski received prompt first aid and emergency services were quickly summoned, however died later in hospital as a consequence of the gun shot.</p>

	<p>A Greater Manchester Police investigation concluded there were no suspicious circumstances, nor any suggestion of third party involvement in respect of his death.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>It is a matter of concern that the continued existence and operation of s11 (4) Firearms Act 1968 enables miniature rifle ranges to operate within only minimal regulation, with attendees able to fire miniature rifles and ammunition not exceeding .23 calibre and air weapons in a largely unregulated environment. In addition, it is a matter of particular concern that the following specific requirements do not currently apply to miniature rifle ranges:</p> <ol style="list-style-type: none"> <li>1) Requirement for the user to sign a prohibited person (Section 21) declaration on each and every visit;</li> <li>2) Requirement for the weapon to be securely tethered so that any projectile discharged from it can only be 'down range';</li> <li>3) Requirement for a competent Range Conducting Officer ('RCO') to be present on the range at all times to enable effective supervision of the shooter;</li> <li>4) Requirement for the weapon to be loaded for the customer by the RCO or other member of staff so ammunition may be accounted for;</li> <li>5) Requirement for the RCO or other member of staff present to be first aid trained with a first aid kit present;</li> <li>6) Requirement for any weapon or ammunition used on the range to be kept secure, controlled and supervised by a member of staff at all times.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 5<sup>th</sup> August 2021. I, the coroner, may extend the period.</p> <p>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</p>

8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and [REDACTED] on behalf of Mr Malinski's family.</p> <p>I have also sent a copy to [REDACTED], Firearms Manager at Greater Manchester Police, who may find it useful or of interest.</p> <p>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.</p>
9	<p>Dated: 10<sup>th</sup> June 2021</p> <p>Signature: <b>Chris Morris HM Area Coroner, Manchester South.</b></p>