IN THE SURREY CORONER'S COURT

IN THE MATTER OF: Malcolm James BASTEN

The Inquest Touching the Death of Malcolm James BASTEN

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • **The Right Honourable Mel Stride Secretary of State for Work and Pensions** • **[redacted], Chief Executive of the Health and Safety Executive**
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
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** The inquest was opened on the 14th March 2016 and resumed and concluded before a Coroner sitting with a jury on the 19th October 2022. The cause of death was: 1a. Cerebral Oedema 1b. Acute and Subdural Haematoma (Operated) 1c. Head and Chest Injuries

	The jury found that: Mr Basten died on 28th February 2016 at St George's Hospital, Tooting while in care for head and chest injuries sustained on 25th February 2016. These injuries were sustained during a fall which took place while working at a height on a construction site in Chaldon. Following the incident, Mr Basten was airlifted to St George's Hospital, where he was diagnosed with an acute subdural haematoma. Mr Basten was operated on for the acute subdural haematoma but following the operation he suffered a cerebral oedema to which he succumbed. Mr Basten had been engaged as a carpenter to work on the roof and started work before the end of January 2016. On the morning of 25th February 2016 Mr Basten was working on the first-floor dormer at the rear of the property at a height of at least 2.5m. This first-floor area was comprised of open wooden joists and an RSJ suspended at least 2.5m above concrete and wooden board. There was no safe internal access to the first floor. This area did not have edge protection and was not completely boarded out. On the day in question, this area was access via an unsecured scaffold ladder. There is no material evidence of planning for the first-floor timberwork regarding health and safety. There was no site supervisor at the time of the incident. The Conclusion was Unlawful Killing
4.	**CIRCUMSTANCES OF THE DEATH** Malcom Basten was working on a domestic building site engaged in constructing the roof at first floor height. Construction work had reached the first floor at least a month before his death but no adequate health and safety measures had been put in place by the principal contractor to safeguard him in his work. There was no edge protection at the place where he fell, no boarding on the open wooden joists and no safe access to the first floor. Access was by means of an unsecured scaffolding ladder which was not designed to be used as a free-standing ladder, it did not have rubber feet and was too short. The Construction (Design and Management) Regulations 2015, Regulation 6 requires the principal contractor to notify the HSE in writing of the project if it is scheduled to last longer than 30 working days and have more than 20 workers working simultaneously at any point in the project or exceeds 500 person days. The size of this contract did not fall within this definition and the HSE were therefore not notified about it.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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. – The evidence showed that: 1. This was a sizable project with considerable work at height. No statutory agency was required to be notified of the work and then inspect the project during the construction. 2. There is no mandatory requirement for the principal contractor to undertake health and safety training from an accredited organisation before engaging in

	this type of project. 3. There is no mandatory requirement for principal contractors to undertake health and safety training from an accredited organisation after an incident such has this has occurred on one of their projects, nor to notify the HSE of any projects they undertake thereafter.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 1st March 2023. 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 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	**Signed:**

	Caroline Topping **Dated this 30th December 2022.**