Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Chief executive - Health and Safety Executive
1	**CORONER** I am Elizabeth WHEELER, Assistant Coroner for the coroner area of Cheshire
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 03 April 2019 I commenced an investigation into the death of Graham FAULKNER aged 64. The investigation concluded at the end of the inquest on 31 May 2024. The conclusion of the inquest was that: "Mr Faulkner died as a result of medical complications arising from an accident at work some years previously. This was contributed to by failures in the administration and management of the Permit to Work process and a lack of challenge, at all levels, around the use of PPE."
4	**CIRCUMSTANCES OF THE DEATH** In October 2015 Mr Faulkner was exposed to caustic soda at work. Mr Faulkner was hospitalised approximately week later, in a serious condition. Within a month, his paraplegia had started. He was not discharged from hospital until 2017. He died in 2019 from the sequalae of his original injury ie exposure to caustic soda.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) **Summary**: The absence any prompt investigation by the HSE to establish the relevant facts and potential gaps in process could have an impact upon the ability to learn from one death and so avoid other deaths.

Further detail

The incident occurred on 15 October 2015. The employer became aware of the incident shortly after 22 October 2015, but initially had limited details.

The HSE were informed of the incident in early November 2015. The RIDDOR report to the HSE noted "Injury preventing the injured person from working for more than 7 days". Separate email correspondence to the HSE at around the same time informed the HSE that Mr Faulkner was in the ICU.

By 4 November 2015, Mr Faulkner had developed paraplegia from the consequences of his initial injuries.

Despite it being known to the HSE that Mr Faulkner had suffered some form of injury with serious consequences (ie ICU admission), the HSE did not investigate. Their records do not show a specific reason for this, but I am informed it did not meet the selection criteria.

The selection criteria are dated 2014 and are still in place today.

These 2014 criteria include incidents which engage the reporting requirements in RIDDOR 4(1). None of these criteria apply to Mr Faulkner.

The investigation criteria does not include the criteria in RIDDOR 4(2) - namely *"Where any person at work is incapacitated for routine work for more than seven consecutive days (excluding the day of the accident) because of an injury resulting from an accident arising out of or in connection with that work, ….*"

It is unclear why the 2014 selection criteria apply to RIDDOR 4(1) and not to 4(2), when both engage statutory reporting criteria.

It is unclear why the criteria in RIDDOR 4(1) do not include injuries resulting in paraplegia, given the life changing severity of such injuries.

If the reason the 2014 selection criteria are relatively narrowly drafted is to avoid excessive expansion of the HSE's duties, it is unclear why there is not a "discretionary" criteria which would allow for investigations where the known facts would suggest that an investigation would be appropriate in accordance with the HSE's wider statutory functions and purpose.

As a result of the HSE decision not to investigate in 2015, various evidence was either not obtained or is no longer in existence. The first witness statement accounts from many eye witnesses date to 2021 or 2022 - some 5 years or more after the events in question.

This has meant that it is challenging to establish the facts that led to Mr Faulkner's injury. Issues that have been in dispute in the evidence have included when the exposure took place, where it took place, the PPE he was wearing and the instructions as to PPE on the permit to work. It is likely that many of these issues would be factually clear(er) if evidence had been obtained in 2015, shortly after the incident, when memories were fresher and

	various paperwork still in existence. The absence of any or any prompt investigation by the HSE to establish the relevant facts and potential gaps in process could have an impact upon the ability to learn from one death and so avoid other deaths.
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, namely by July 26, 2024. 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 - **Mr Faulkner's family** - **Industrial Chemicals Ltd ("ICL")** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 13/06/2024**  **Elizabeth WHEELER** **Assistant Coroner for** **Cheshire**