Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Operations Director, Tenancy and Homeowner Services, London Borough of Hackney**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner, for the coroner area of Inner North 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 2 July 2024, HM Senior Coroner Mary Hassell commenced an investigation into the death of Sarah McGreevy aged 37 years. The investigation concluded at the end of the inquest on 6 November 2024. The conclusion of the inquest was that Ms McGreevy had died from injuries sustained when she fell from her balcony on 16 June 2024. I returned a conclusion of accident. The medical cause of Ms McGreevy's death was: 1a multiple injuries, 1b trauma, 1c fall from height.
4	**CIRCUMSTANCES OF THE DEATH** Ms McGreevy was the assured shorthold tenant of [redacted]. The property is a 2-bedroom flat on the 6th floor. The freeholder of the premises is London Borough of Hackney. Around 9.40 am on 16 June 2024, Ms McGreevy fell to the ground from her balcony and sustained fatal injuries. Police officers attended the scene and noted that there was a wooden box on the balcony and Ms McGreevy's mobile phone was on a window ledge next to the balcony. The phone was close to a downwards drainpipe which came from the floor of the 7th floor balcony above Ms McGreevy's flat before diverting down the exterior wall to the block. The pipe had previously been repaired using heavy duty tape. Residents made police officers aware of

	problems with the guttering and drainpipes in the block. Police were told of residents on the 5th and 6th floors climbing onto their balconies to manually unblock pipes, particularly following heavy rainfall. The Police investigation did not reveal any evidence to suggest that anyone else was involved in Ms McGreevy's death or that she had any suicidal intent. Photographs taken of Ms McGreevy's hands following her death show dirt around her fingernails consistent with undertaking a cleaning task. I found that it was more likely than not that Ms McGreevy had climbed onto the wooden box to clear the pipe and had accidentally fallen over the balcony.
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. – (1) Several [redacted] residents reported a practice of climbing onto their balconies in order to clear blocked drainpipes. This practice carries a clear risk of falls. (2) The leaseholder of [redacted] informed me that he was not aware of any work being undertaken to the guttering or drainpipes to the block following Ms McGreevy's death. (3) In the absence of remedial works, the practice of residents unblocking pipes themselves is likely to continue.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1 January 2025. 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: (1) [redacted] (parents of Sarah McGreevy) (2) [redacted] (leaseholder of [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. She 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	**Sarah Bourke** **HM Assistant Coroner** **6 November 2024**