REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Health and Safety Executive**
1	**CORONER** I am Nicholas Leslie Rheinberg assistant coroner, for the coroner area of Wiltshire & Swindon
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 20th September 2016 an inquest was opened into the death of Peter David Konitzer aged 63. The investigation concluded at the end of the inquest on 21st March 2025. The conclusion of the inquest was that Peter David Konitzer died on 24th August 2016 as a result of compression of the chest. The jury concluded that the deceased had been unlawfully killed.
4	**CIRCUMSTANCES OF THE DEATH** Peter David Konitzer worked as a volunteer for Wilts & Berks Canal Trust in relation to a project to rehabilitate the top lock of the Wilts and Berks canal at Pewsham. The work involved elements of heavy construction outside the experience and capabilities of the volunteer workforce employed. Senior management of the canal trust failed to manage the project in an efficient and legally compliant manner partly through ignorance of their legal responsibilities. Mr Konitzer died when removing props behind a recently excavated retaining wall which collapsed onto him. As a result of senior management failures to manage the project in a manner so as to preserve the safety of those involved in the execution of the works the trust was prosecuted and pleaded guilty. There appeared to be lack of understanding by the trust of the legal obligations set by the Construction Design Management Regulations and little appreciation of relevant standards and guidance such as are to be found by reference to British Standards and HSE Guidance. In particular there was ignorance of the requirement for temporary works designs, risk assessments and method statements and the need to have completed full designs, project identification documents, construction phase plans, including health and safety plans and risk assessments, prior to starting work.
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. The HSE website has a section on Volunteering which provides links to more detailed sections elsewhere on the website. No where is it emphasised that as a matter of good practice before undertaking any construction work risk assessments and method statements should be in writing even when there is no legal requirement to do so. Many charitable trusts have a large number of volunteers working for them but with under 5 actual employees technically escape the legal requirements for such documents to be in writing. 2. Subsequent to the conviction of the Canal Trust for breaches of health and safety legislation the HSE published a bulletin. Will consideration be given to publishing a further bulletin following the finding of the inquest jury that Peter Konitzer was unlawfully killed? Such a bulletin might serve as a stark warning to others embarking on similar projects. 3. Will thought be given to revising the Volunteering section of the website to provide a more comprehensive and standalone guide to the obligations of charitable trusts and voluntary organisations? Might such revision profitably include a section reminding organisations that rely on volunteers that enthusiasm should be tempered by being mindful of the need to obtain proper professional advice and assistance in appropriate circumstances?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 21st May 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 deceased's family and the Wilts & Berks Canal Trust. I have also sent it to the Inland Waterways Association and the Canal & River Trust 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 other 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.
9	**25th March 2025** ***N.L.Rheinberg*** **Assistant Coroner**