


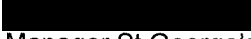


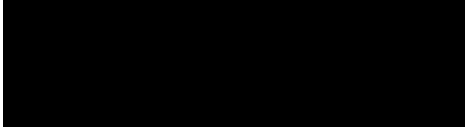


## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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|   | <p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>████████████████████<br/>Secretary of State for Housing, Communities and Local Government,<br/>2, Marsham Street,<br/>London.<br/>SW1P 4DF</p> <p>████████████████████<br/>Secretary of State for Health and Social Care<br/>39, Victoria Street,<br/>London.<br/>SW1H 0EU</p>  |
| 1 | <p><b>CORONER</b></p> <p>I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London</p>   |
| 2 | <p><b>CORONER'S LEGAL POWERS</b></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>   |
| 3 | <p><b>INVESTIGATION and INQUEST</b></p> <p>On 12<sup>th</sup> June 2025 at 13:39 hours, an Air India Boeing 787 took off from Ahmedabad Airport, India to fly to London Gatwick. It crashed 32 seconds after take-off, falling from an altitude of 600 feet. 241 people died who were on the aircraft, and at least 19 people who were on the ground. There was one surviving passenger.</p> <p>No inquests have yet been heard. This report is based upon my duty under Regulation 28 being engaged in respect of the hazard presented to all mortuary users from the method in which bodies of deceased persons being repatriated to the UK were preserved and returned.</p> |
| 4 | <p><b>Evidence relevant to the matters of concern.</b></p> <p>Following the incident a number of deceased persons were repatriated to Westminster Public Mortuary. The remains of these deceased persons were wrapped and saturated in high concentrations of formalin (apparently 40%) as a preservative and returned in lined coffins. On opening the coffins, it was apparent that</p>  |

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|   | <p>there was a significant chemical hazard from the formalin to all users of the mortuary.</p> <p>Expert evidence was sought from Police CBRN, the EPA, the pathologist etc and appropriate systems were put in place to mitigate the risk including the use of environmental monitoring, breathing apparatus and other appropriate equipment.</p> <p>It became apparent that many of the mortuary users appeared unaware and were surprised by the nature of the danger from the formalin, which is commonly used to preserve human remains and especially when bodies of deceased persons are repatriated from abroad. It is apparently not usual for environmental monitoring to be routinely available in either public or hospital mortuaries.</p> <p>Expert advice summarised the danger of formalin to be that formalin contains formaldehyde.</p> <p>This substance can cause severe respiratory irritation.</p> <p>It is a volatile substance which means that it disperses into the atmosphere.</p> <p>It is carcinogenic and is known to cause acute myeloid leukaemia.</p> <p>It has toxic effects including metabolic acidosis, bronchospasm, pulmonary oedema and death.</p> <p>With heat and light exposure it breaks down releasing carbon monoxide which is highly toxic.</p> <p>If it mixes with a source of ammonia (commonly seen with decomposition), cyanide which is also highly toxic can be released.</p> <p>Levels of formalin were found to be dangerously high, and carbon monoxide and cyanide were also detected in the mortuary at dangerous levels following open of the coffins and unwrapping of the bodies of the deceased persons who had been repatriated.</p> |
| 5 | <p><b>Matters of Concern</b></p> <ol style="list-style-type: none"> <li>1. There is an under appreciation across mortuaries of the dangers posed by formalin to the health of all mortuary users.</li> <li>2. That mortuaries frequently receive bodies preserved in formalin.</li> <li>3. That formalin is not routinely monitored in mortuaries.</li> <li>4. That as such appropriate equipment may not be available nor used when mortuaries handle bodies significantly contaminated with formalin, thus exposing users of mortuaries to health risks including risk of death as outlined above in box 4.</li> </ol>  |

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| 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/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.</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. 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 to the following Interested Persons:</p> <p><br/>Chief Executive Westminster City Council (by email)</p> <p><br/>Manager Westminster Mortuary (by email)</p> <p><br/>Forensic Pathologist (by email)</p> <p><br/>Manager St George's Hospital Mortuary (by email)</p> <p><br/>President Royal College of Pathologists,<br/>6, Alie Street,<br/>London.<br/>E1 8QT.</p> <p><br/>President of the Association of Anatomical Pathology Technology (by email)</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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><b>10th November 2025</b></p> <p></p> <p><b>Professor Fiona J Wilcox</b></p>   |

**HM Senior Coroner Inner West London**

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