H.M. Senior Coroner, South London Area

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Coroners & Justice Act 2009; Coroners (Investigation) Regulations 2013 Regulation 28: report to prevent future deaths

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Bromley Council**
1	**CORONER** I am senior coroner for the South London coroner area
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** In January 2013 I commenced an investigation into the death of Elsie Gibson, aged 94. The investigation concluded at the end of the inquest on 15th October 2013.
4	**CIRCUMSTANCES OF THE DEATH** Elsie Gibson slipped off the pavement whilst circumventing an unlicensed scaffold tower erected outside premises in High Street Bromley on 4th January 2013. She was conveyed by ambulance to hospital where a fractured hip was diagnosed and treated. She died in hospital on 9th January 2013. The underlying pathological cause of death was the fracture, the result of the accidental fall.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Mrs Gibson was injured when she slipped off the kerb whilst circumventing a narrowed pavement, caused by the erection of an unlicensed scaffold tower, outside premises in High Street Bromley on 4th January 2013. She later died of her injuries. The scaffolding tower was erected without the necessary formalities.

	When the incident was reported to the Council by the son, it does not appear to have been investigated promptly. I understand that the Council is the Highways Authority and presume that it is for the Council to take all necessary action. The son supplied photographic and other evidence at the inquest. I was told in evidence at the inquest that there is no contemporaneous evidence, in note form or otherwise, of the inspection that did take place. I refer to the evidence given to me by [redacted] the Council's Technical Support Team Leader for Environment and Community Services. It seems to me that it would not be unduly difficult to ascertain (whether from Roosters PiriPiri or from the property landlord) who arranged for the erection of the scaffolding and then to take appropriate action. However, I understand that no enquiries of that kind have been made and it seemed from evidence given to me that no such action is contemplated. As coroner, I have a duty to the citizens of my area to take appropriate steps to prevent future deaths when there is a continuing risk. If no action is taken it is likely to lead others who might need to erect scaffolding towers to decide that there is no need to seek formal permission because no action is taken by the Highways Authority when others do so without consequences, even in circumstances where passers-by are injured. I invite the Council to reconsider whether there is not an obligation to investigate the incident and to take action against the person(s) who erected the scaffold tower without license and, albeit without intending to do so, caused a passer-by to be injured and to die from those injuries. If no action is taken, others may well believe that they can do as they please without license and not have to face any consequences of their action. If action is taken, and publicity given, it may lead others to adhere to the necessary formalities.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Council, as the Highways Authority, 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 December 24th 2013. I may extend the period if you so request. 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 son of the deceased. 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	**Dr R N Palmer** *H M Senior Coroner, South London Area* **21st October 2013**