	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS Re Alan Walsh 02602-14, died 07.10.14 (JB) THIS REPORT IS BEING SENT TO: 1. Health and Safety Executive: [redacted], Head of Operational Strategy, HSE, Osprey House, Colchester Road, Chelmsford CM2 5PF 2. Department for Business Energy and Industrial Strategy: [redacted], Regulatory Delivery, BEIS, 1 Victoria Street, London SW1H 0ET 3[redacted], Commercial Director, Youngman, The Causeway, Heybridge, Maldon, Essex CM9 4LJ
	CORONER I am Andrew Harris, Senior Coroner, London Inner South
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 I opened an investigation into this death on 16.10.14 after the deceased had fallen from a ladder and died the same day from injuries sustained in the fall. The matter was investigated by the HSE. An inquest was opened on 26.02.16 and concluded before a jury on 18th January 2017. Accident was the conclusion of the jury as to the death.
4	CIRCUMSTANCES OF THE DEATH The deceased fell from a 2.5m Combination (Combi 100) Youngman's A ladder whilst inspecting a fault in a 12.5 foot or 3.8m ceiling void at Eltham Leisure Centre. The deceased fell with the ladder, which was found under the deceased, and was deformed with missing spigots. The jury reached no conclusion on why the accident had occurred. The deceased was experienced in use of this ladder. [redacted] HM Inspector of Health and Safety, was reluctant to give an opinion. But the court inspected the damaged and undamaged ladders and heard that:

	1. The inspector advised that the spigots or stops were safety critical. They maintain the position of middle and lower sections relative to each other in the A mode, to ensure that they cannot be separated. The lower spigot on C is to stop C section sliding up too far. 2. The role of the spigots was not appreciated by the salesperson from ladder hire company, (which has since drawn attention to these in their hire agreements) nor by the assistant to the deceased. HSE had not issued any statements on these. 3. The inspector concluded that the ladder was erected in the A position with 4 rungs showing above apex, at the time of its usage in the Leisure Centre. 3. He said that the positions adopted by the deceased on the ladder were safe and its use was within the safe use intended by the design. The ladder was not being footed at the time. 4. He said that premature opening of the ladder without undue force prior to erection can cause the spigots to suddenly shear off. 5. He agreed that the deformation of the ladder could not have been present before the accident as the ladder could not be put back together in the used position. 6. He said that if the ladder was not locked properly at the apex it would on the balance of probabilities collapse on usage. If it was locked it would not be in the position and state it was after the accident. If it fell with the deceased, as the jury concluded, [redacted] concluded it was not locked.
5	CORONER'S CONCERNS The **MATTER OF CONCERN** is as follows. – There would appear not be awareness of the safety critical role of the spigots on this ladder, nor the fact that they can easily and inadvertently be sheared off, on premature opening of the ladder. Whilst the absence of these spigots was not found to be the cause of this accident, they may have had a role in the injuries sustained and the implications of the lack of awareness may create risks to health and safety.
6	ACTION SHOULD BE TAKEN I consider the evidence given at this inquest gives rise to a concern that circumstances creating a risk of other deaths will occur and in my opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. I am therefore reporting this matter to those who manufacture and regulate and inspect usage of this ladder.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th April 2017. 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. If you require any further information about the case, please contact the case officer, [redacted] If you require further information about the process of responding to this report please contact my clerk [redacted] to whom your response should be sent.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted] of Slater & Gordon UK LLP for [redacted] (widow), [redacted] Senior Associate of DWF LAW for Argent FM, [redacted] of DAC Beachcroft for HSS Hire, [redacted] of Weightmans LLP for Royal Borough of Greenwich and [redacted] HM Inspector of Health & Safety. I am also sending a copy to [redacted] Chartered Medical Engineer and Health & Safety Practitioner for Oliver & Rawden Consulting Forensic Engineers. 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	[DATE] 3rd March 2017 [SIGNED BY CORONER]