Regulation 28: Prevention of Future Deaths report

Codrut IEDERAN (died 03.12.14)

	THIS REPORT IS BEING SENT TO: **1. Mr Brendan Bacon** **Director** **Zelltec Limited** **41 Brownfields** **Welwyn Garden City** **Hertfordshire** **AL7 1AN**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 5 December 2015, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Codrut Iederan, aged 30 years. The investigation concluded at the end of the inquest on 23 November 2014. The determination made at inquest by the jury was of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Just before 9am on 3 December 2014, whilst working at the Anchor and Hope Public House construction site, Mr Iederan pushed an unstable wall which then collapsed on him.

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. I heard at inquest that the site manager for the Anchor and Hope Public House construction was the site first aider, but he was off site at the time of the fatal accident. The remaining four workers were all Romanian non native English speakers, and none was first aid trained. Mr Iederan had the best English of the four, but of course after the accident he was not in a position to help himself. When one of his colleagues tried to call an ambulance, he realised that he did not know the number. He asked a passer by and so no time was lost in this case. However, when I asked him in court if he now knew the number, some eleven months after Mr Iederan's death, he did not, despite still being employed by Zelltec. I am conscious that many construction sites in London are heavily supported by foreign workers. It seems to me that it would be of great assistance if employers and site managers were to ensure that all members of their workforce were able to summon help in an emergency. In addition to signs (perhaps in languages other than English) with the 999 number displayed clearly, this could be covered in toolbox talks – of course how it is done is of course a matter for you.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 February 2016. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Health and Safety Executive • [redacted], partner of Codrut Iederan 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 03.12.15