REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Spaces and Places Limited (DWF Solicitors) 2. Health & Safety Executive [redacted] 3. The British Standards Institute 4. Family [redacted] Fentons Solicitors)
1	**CORONER** I am Mr Simon Nelson, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 8th March 2013 I commenced an investigation into the death of **Myra Goldman** for whom the cause of death was given as being that of 1a) Traumatic Asphyxia and at an Inquest convened with a Jury at the Oldham County Court on the 5th November 2014, the conclusion of the Jury was that of an 'accidental death' with the Jurors unanimously stating in answer to question 3 of the Record of Inquest that 'her death was caused by a palisade gate falling on her due to fatigue of the lower right hand hinged eye bolt plus configuration of the lugs and hinge pins'.
4	**CIRCUMSTANCES OF DEATH** The palisade style gate was at the entrance to a number of storage units. A diagram confirming the configuration of the hinges to that gate is annexed and shows that each hinge was formed by a hinge pin welded onto the gate post and an eye bolt bolted through the stile of the gate and fastened by two nuts. The lower hinge pin had been welded so that its pin was above its lug. The upper hinge was welded so that its pin was below the lug i.e. they were the inverse of each other and therefore the lower eye bolt would have been taking the majority of the vertical static load of the gate. Impingement of the gate on the gate post was the primary cause of insidious fatigue cracking in the lower eye bolt and when this failed, the gate dropped until the upper eye bolt was clear of its own hinged pin at which point the gate was free to topple sideways.
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:- The inversion of the upper hinge pin is not an uncommon practice and is intended to prevent a gate from being easily lifted off its hinges. BS 1722-12:2006 specification for steel palisade fences which states that 'hinges shall be designed so that it is impossible to remove the gates by lifting at the hinges when they are in the shut and locked position'. The standard gives examples of hinge arrangements and does not specifically preclude this method. In the opinion of HM Specialist Inspector (Mechanical Engineering) of the Health & Safety Executive who gave evidence at the Inquest 'the common sense approach is to spread the load' between hinges by orientating them the same way rather than putting the significant majority of the weight of the gate onto one hinge only and 'to prevent the gate from being easily lifted off, a

	proprietary method should be used such as double – lug hinge or anti-theft collars or split pins'. The preference of HM Specialist Inspector was for the standard to be 'changed'. Any change can only be considered / implemented at a review meeting of the British Standards Institute.
6	**ACTION SHOULD BE TAKEN** **The content of BS 1722 – 12:2006 specification for steel palisade fences be reviewed at the next meeting of the British Standards Institute with a view to the prevention of future fatalities.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 05/01/2015. 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 following Interested Persons namely:- 1. Spaces and Places Limited (DWF Solicitors) 2. Health & Safety Executive [redacted] 3. The British Standards Institute 4. Family (Fentons Solicitors) 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 from. 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: 10th November 2014 Signed:

Annexed Diagram A

HMC COURT COPY

C1

RESTRICTED

A

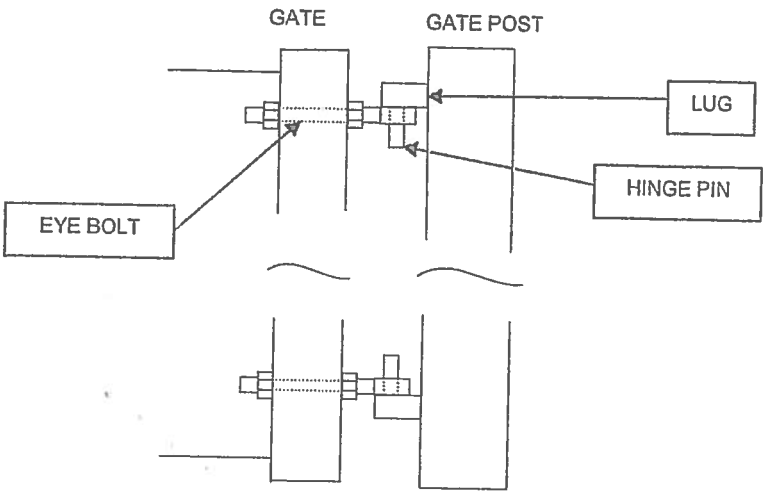

Figure 1

Not to scale

B

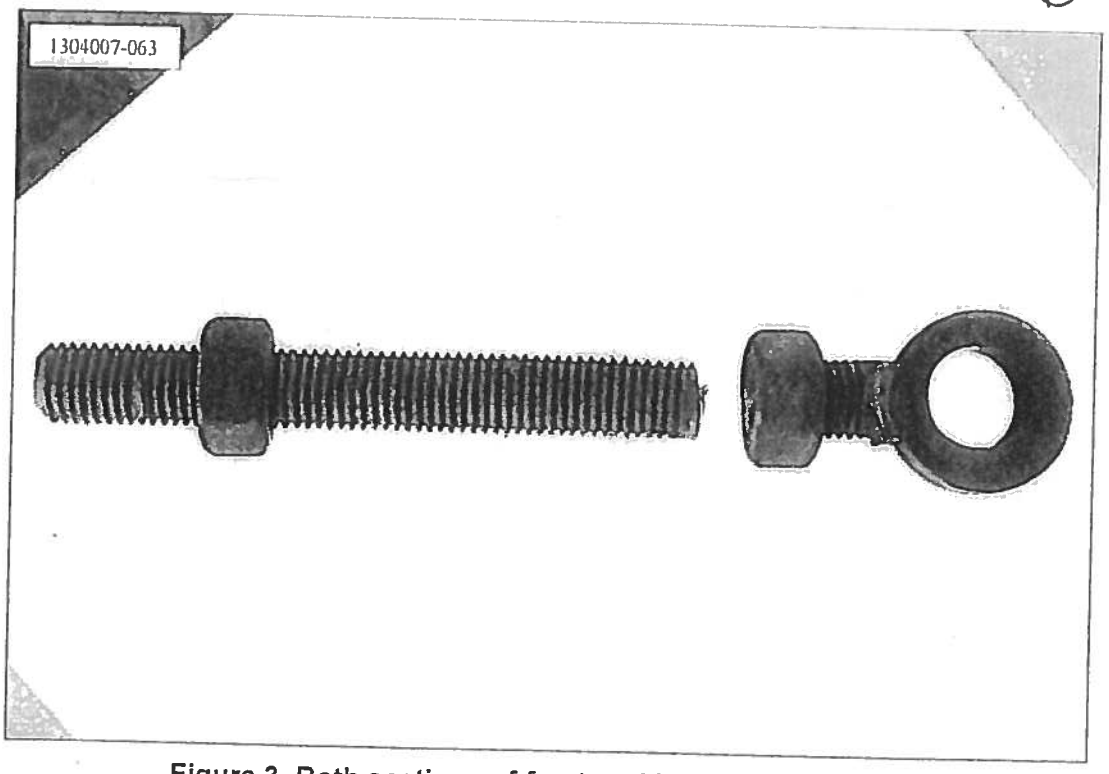

Figure 3. Both sections of fractured lower hinge eye bolt