IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Shaun MASLIN
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • The Secretary of State for the Department of Business, Innovations and Skills. • The Chief Executive of the Energy and Utilities Skills ('EUS').
1	**CORONER** Richard Travers HM Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Shaun Maslin's** death was opened on the 25th October 2011 and was resumed on 12th June 2014 with a jury. It was concluded on 18th June 2014. The jury found that the cause of death was: **1a: Multiple Injuries, including spinal cord laceration at the base of the brain.** They concluded with the short form conclusion: **Accidental Death**.
4	**CIRCUMSTANCES OF THE DEATH** On the morning of the 21st October 2011, Mr MASLIN was working with his team of two men, on a gas main situated adjacent to the A30 between the M25 and the Crooked Billet roundabout in Staines, Surrey. During the course of the morning Mr Maslin proceeded to undertake a medium pressure test on the part of the pipeline which crossed the river Colne, it was known as the 'River Crossing'. The works formed part of the NLGA 7600 project which was concerned with the replacement of the

	Twickenham medium pressure gas main. That project formed part of a larger project being undertaken by the North London Gas Alliance which was made up of National Grid Gas plc and Skanska plc. The Alliance had subcontracted work to a company by the name of RBS Utilities and that company had in turn sub-contracted some of the work to Mr Maslin's company SM Plant Hire Ltd. The pressure test had not been authorised under the NLGA's Safe Control of Operations procedures and it was conducted in a manner that did not comply with the NLGA's practice requirements. The jury concluded that, despite the above, there was agreement that the pressure test should be undertaken. During the course of the test and whilst the pipe was under pressure, the bracing which had been fitted by Mr Maslin broke with the result that one of the one of the end caps that had been fitted by Mr Maslin came away and struck Mr Maslin causing him the injuries from which he subsequently died. He was pronounced dead at the scene at about 12.00 hours that same day. During the evidence it became apparent that Mr Maslin did not have the necessary qualifications / competences to undertake this type of medium pressure, but no one in the management chain were not aware of that. Further, the evidence demonstrated that pressure testing a pipe at all levels, including low and medium pressure, was in itself a very dangerous task, particularly, if it was undertaken without proper safety precautions being in place.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTERS OF CONCERN** are as follows: – 1. By reason of the dangers involved in pressure testing gas pipelines, consideration should be given to making such tests the subject of their own specific qualifications. 2. There is no national requirement for operatives within the gas industry to be retrained and tested once they have obtained their initial qualifications. Consideration should be given to imposing a national requirement that all operatives in the gas industry be subject to a five yearly review and re-testing of their qualifications.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Secretary of State for Justice has the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the Chief Coroner and the Interested Persons in the Inquest, namely: • Shaun Maslin's Family – [redacted] • [redacted] Irwin Mitchell • National Grid Gas plc – [redacted] • Skanska UK plc – [redacted] Kennedys Law • RBS Utilities – [redacted], Beachcroft Solicitors • Aviva on behalf of SM Plant Hire Ltd – [redacted] - DWF • The Health and safety Executive – [redacted]
9	**Signed:** *Richard Travers* **DATED this 19th day of June 2014**