Regulation 28: Prevention of Future Deaths report

Richard LACO (died 06.11.13)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Contracts Director** **CMF Limited** **Central Way** **Feltham** **Middlesex TW14 0XJ** **2. [redacted]** **Managing Director** **Laing O'Rourke UK & Europe** **Bridge Place 2** **Anchor Boulevard** **Admirals Park** **Crossways** **Dartford** **Kent DA2 6SN**
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 13 November 2013, one of my assistant coroners, Richard Brittain, opened an investigation into the death of Richard Laco, aged 31. The investigation concluded at the end of the inquest on 16 October 2015. The jury made a narrative determination, which I attach.

4	**CIRCUMSTANCES OF THE DEATH** Richard Laco died on the building site at the Francis Crick Institute, when a landing fell on him as it was being tilted into place.
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. 1. The fitting of the two below ground landings in core D of the development at the Francis Crick Institute utilised a different methodology to the landings already fitted in cores A and F. The shape of the landings was trapezoid rather than rectangular; and they were lowered vertically to ground level and then later raised & tilted to pass the side fins; rather than simply being lowered from the top directly into place. However, no part of the method statement, risk assessment or lift plan recognised that. There was no description of the different process; there was no instruction to stop the procedure if positive fixings (i.e. feeding the slings through eye bolts) could not be achieved; and there was no indication that the wide rather than the narrow end of the landing should be tilted down with the tag lines. The need for such a plan was not identified by CMF in drafting the planning documents, nor by LOR in checking and approving them. 2. Not only was there no appropriate plan in place for the fitting of the two basement landings in core D, at inquest nearly two years after the event, some site witnesses did not appear to see the need for such a plan. Some witnesses did not appear familiar with basic terminology, despite still holding a pivotal role in planning/approving the plans for such processes, and gave evidence that did not demonstrate clarity of understanding of the processes.
6	**ACTION SHOULD BE TAKEN**

	In my opinion, action should be taken to prevent future deaths and I believe that you and your organisations 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 21 December 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Health & Safety Executive • [redacted], mother of Richard Laco • [redacted], LOR package manager • [redacted] LOR appointed person • [redacted], CMF site manager • [redacted], CMF lift supervisor • [redacted] CMF site supervisor • [redacted] CMF lift supervisor • [redacted], CMF fitter 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** 22.10.15