REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr Colin Wood, Chief Executive, Construction Plant-hire Association, 27/28 Newbury Street, Barbican, London EC1A 7HU**
1	**CORONER** I am David Clark, Assistant Coroner for the coroner area of Warwickshire.
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 and INQUEST** On 28 May 2015, I commenced an investigation into the death of Mark Richard Seward, aged 49 years. The investigation concluded at the end of the jury inquest on 31 March 2016. The conclusion of the jury was that Mr Seward died from a head injury and that his death was the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Seward was an experienced fitter, mechanic and engineer who had started work at AGD Equipment Limited (AGD) in Stratford-upon-Avon on 10 May 2015. On 27 May 2015, in the course of his employment, he was using a portable Enerpac pump to test a cylinder for an oil leak. At 11.19, the valve block on the cylinder fractured due to excessive pressure. The resulting explosion caused an ejection of metal and other debris at high speed. Mr Seward was crouching at close proximity to the cylinder. He was not wearing protective headware and was not shielded by a protective screen. He was struck by debris, resulting in a serious head injury. He was taken by air ambulance to University Hospital, Coventry, where he died at 14.35 the same day.
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 could 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) There was a lack of clarity as to what type of activity amounted to pressure testing. (2) The degree of compliance with the Provision and Use of Work Equipment Regulations 1998 (PUWER) and guidance issued by the HSE such as GS4 was called into question, not only at AGD but more widely within the industry. Witnesses gave evidence that the poor practices followed at AGD were replicated elsewhere.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. The particular circumstances which led to Mr Seward's death are unlikely to recur at AGD because pressure testing is now sent off-site. However, my concerns relate more widely and include the proper understanding of pressure testing and the safe management of associated risks across the industry. Your organisation appears to be well-placed to assist with raising awareness of these concerns. The action I am asking of you should include an explanation of the steps you are taking to raise awareness of the risks associated with pressure testing, and of how companies and individuals can gain access to guidance from the HSE. I have written separately to the Managing Director of AGD.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31 May 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 Chief Coroner and to Mr Seward's family and legal representatives. I have also sent a copy to [redacted] HM Inspector of Health and Safety. I am aware that [redacted] has recently visited AGD. I am 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 of REPORT** **5 April 2016** **David Clark, Assistant Coroner**