## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted] Managing Director, AGD Equipment Limited, Avonbrook House, 196 Masons Road, Stratford-upon-Avon CV37 9LQ** |
| 1 | **CORONER**<br><br>I am David Clark, Assistant Coroner for the coroner area of Warwickshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>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**<br><br>Mr Seward was an experienced fitter, mechanic and engineer who had started work at AGD Equipment Limited (AGD) on 11 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**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>(1) It was unclear who had responsibility for Health and Safety issues at AGD at a strategic (ie. Board) level and operationally.<br>(2) There was no specific risk assessment or method statement for the type of work being carried out by Mr Seward.<br>(3) No instruction manual had been provided to AGD to give clear instruction on how the Enerpac pump should be used.<br>(4) AGD managers and staff had not accessed computer-based material relating to health and safety issues. |

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. I recognise that 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 to the approach taken by AGD to manage health and safety risks appropriately.<br><br>The action should include an explanation of the steps you have taken to raise awareness of health and safety issues at AGD; how you train staff and monitor compliance; and how guidance from the HSE and others is stored and disseminated. |
| 7 | **YOUR RESPONSE**<br><br>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.<br><br>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**<br><br>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 have sent a separate report to the Chief Executive of the Construction Plant-hire Association relating to the effective dissemination of guidance on pressure testing.<br><br>I am under a duty to send the Chief Coroner a copy of your response.<br><br>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**<br><br>**5 April 2016** **David Clark, Assistant Coroner** |