## 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>**The Glass and Glazing Federation, 44 -48 borough High Street, London SE1 1XB** |
| 1 | **CORONER**<br><br>I am Kevin McLoughlin, Assistant Coroner for the coroner area of Inner West London |
| 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**<br><br>**On 10 June 2015 an investigation was commenced into the death of Andrew Terrance John Lownes who was 51 years of age, having been born on 10 June 1963. The Investigation concluded at the end of an Inquest on 2 March 2017. The jury returned a Narrative Conclusion with the medical cause of death being 1a Severe crush injury to the chest** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 5 June 2015 the deceased was working on the 17th floor of a construction site at Eastbourne Terrace, London acting as a slinger/signaller for a company installing glass curtain window units ('GCWU') as part of the refurbishment of an office block. He was fatally injured when a GCWU toppled from the transport stillage it was positioned on in the working area on the 17th floor. |
| 5 | **CORONER'S CONCERNS**<br>Evidence taken during the Inquest gave rise to a concern, in my opinion, that future deaths will occur unless action is taken. In such circumstances it is my statutory duty to report the matter to you as an organisation which may have the power to take action.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>1. The consignment of GCWUs which arrived on site from a factory in Switzerland was not accompanied by written unloading instructions, despite:<br>• Containing two GCWUs each weighing around 600kg<br>• The narrow nature of GCWUs -- which meant they were likely to fall if not adequately secured to the transport stillage at all times.<br>• The relatively complex nature of the banding arrangements which secured the GCWUs to the transport stillage, involving some bands which were around the individual GCWU alone, others which lashed a particular GCWU to the stillage and others which sought to bind the entire consignment. Some of the bands lay positioned on top of other bands which served a different purpose. The entire load was shrink wrapped which added to the difficulty of identifying the function and route of a particular band around the load. |

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| | In consequence, it was not obvious to those unloading the consignment which band served which purpose. This gave rise to a risk that in the course of unloading a band might be cut inadvertently resulting in the fall of a heavy GCWU. Workers in the vicinity could be in a position of jeopardy, as was the case here.<br>Evidence was taken from an expert witness who had considerable experience in construction site management. He said when he examined an identical consignment after the tragedy it took him over an hour to work out the function of the multiple bands placed on the consignment.<br><br>2. Although not relevant to the Inquest into Mr Lownes' death, it is pertinent in my judgment, to refer to another Inquest which I conducted in Leeds in 2009 involving the death of Alan Fletcher, a man aged 59 who sustained fatal crush injuries whilst unloading a container of GCWUs in Leeds. Although that incident involved goods shipped in a container from the UAE rather than on a stillage, there are common features between the two cases:<br>➢ The absence of unloading instructions<br>➢ Tall, heavy, narrow based items which have the potential to cause harm if not secured at all times. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe the Glass and Glazing Federation have the power to take such action by virtue of your role in the glass industry and the Code of Practice you publish.<br><br>I do not seek to recommend a particular course of action to you, but ask that consideration be given to standardised systems which in a global industry may assist workers on site facing the challenge of unloading such consignments safely, including colour coding of securing straps, pictogram unloading instructions and suchlike. |
| 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 11 May 2017. 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 the following Interested Persons :<br>1. [redacted] the widow of Mr Lowne<br>2. Felix Construction SA<br>3. Overgate Developments Limited<br>4. Wates Construction Limited<br>5. Health & Safety Executive<br><br>I am also 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. |

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| 9 | Kevin McLoughlin. 13 March 2017<br><br>**Mr Kevin McLoughlin MA, MA, BA,CMIOSH, Barrister-at-Law**<br>**Assistant Coroner**<br>**Inner West London,**<br>**Westminster Coroner's Court,**<br>**65, Horseferry Road,**<br>**London.**<br>**SW1P 2ED.** |