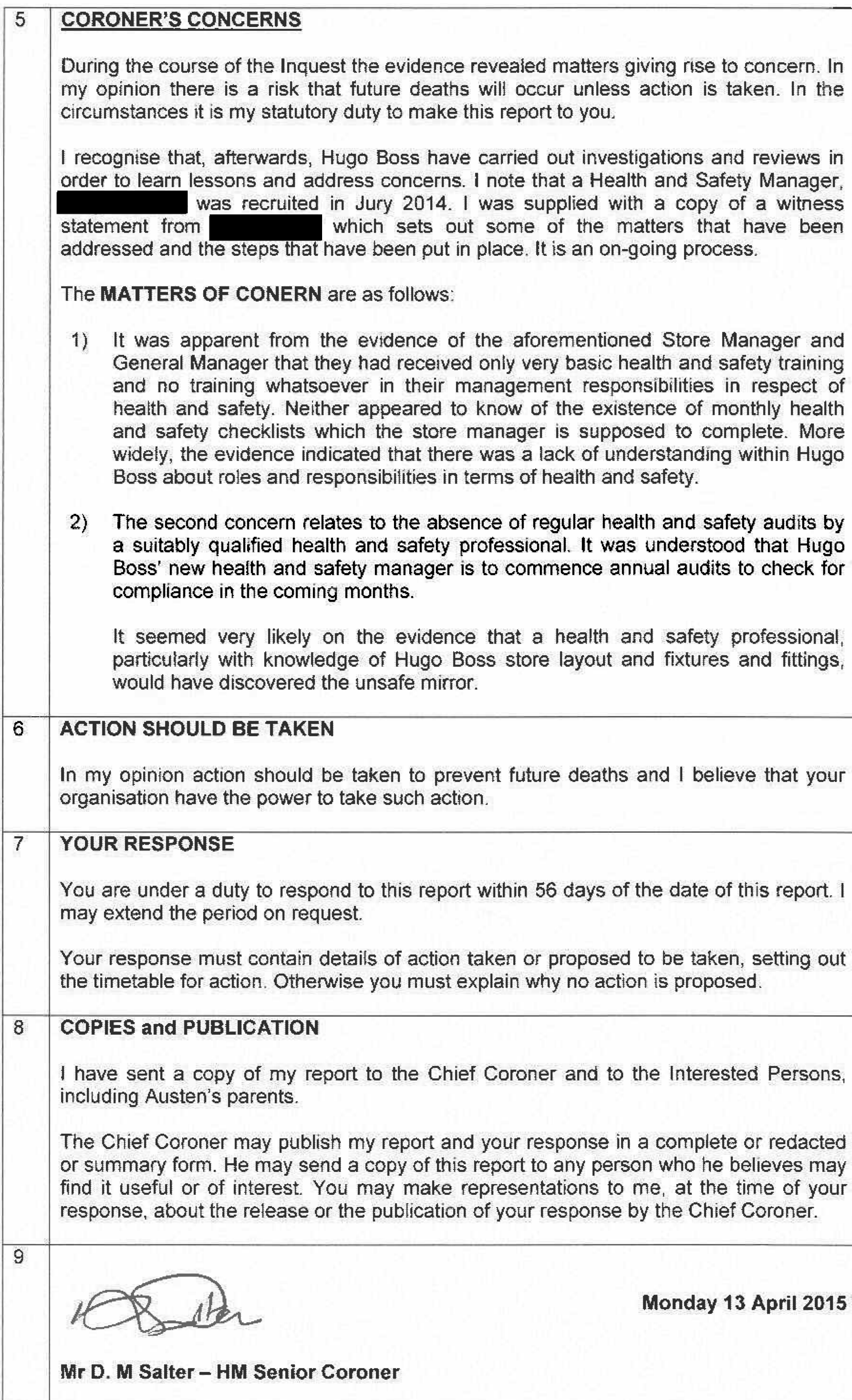
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [REDACTED] **Managing Director of Hugo Boss UK**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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 19 June 2013 I opened an Inquest into the death of Austen Harrison, aged 4, who died on 8 June 2013 at the John Radcliffe Hospital, Oxford. The case was concluded with a Jury Inquest at Oxford Coroner's Court on Wednesday 25 March 2015. The Jury returned a Narrative Conclusion as follows: *Austen died at approximately 0545hrs on 8th June 2013 at the John Radcliffe Hospital, Oxford. The death was the result of an incident of a mirror falling on him in the Hugo Boss Store, Unit 27, Bicester Village, on the 4th June 2013 at approximately 2030hrs.* *The mirror came to fall on Austen after he moved the wings, causing the unfixed mirror to become unstable. The jury believe the mirror should have been fixed to a wall and that wall should have been re-enforced. We do not believe the mirror was fixed to the wall. Nor are we able to say who moved the mirror to its final position. The mirror was moved within the store to its position in the fitting room between 14th September and 3rd December 2012.* *We believe a risk assessment should have been conducted post-works to ensure the mirror was fixed securely to the wall based on the fitting instruction document.* *We believe there were health and safety systems in place, but are not confident these systems would have avoided any danger posed by the mirror. In any case, these systems appear to have not been followed.* Your Company was represented at Inquest by [REDACTED] A number of current and former employees were among the witnesses to give oral evidence, including the former Store Manager, [REDACTED] and the General Manager, [REDACTED]
4	**CIRCUMSTANCES OF THE DEATH** I realise of course that the circumstances of Austen's tragic death will be very well known to you. The circumstances were briefly summarised by the Jury in the Narrative Conclusion. Austen sadly died from a severe head injury after he was struck by a three way mirror which should have been fixed to a reinforced wall but was left free standing.



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 make this report to you. I recognise that, afterwards, Hugo Boss have carried out investigations and reviews in order to learn lessons and address concerns. I note that a Health and Safety Manager, [REDACTED] was recruited in Jury 2014. I was supplied with a copy of a witness statement from [REDACTED] which sets out some of the matters that have been addressed and the steps that have been put in place. It is an on-going process. The **MATTERS OF CONERN** are as follows: 1) It was apparent from the evidence of the aforementioned Store Manager and General Manager that they had received only very basic health and safety training and no training whatsoever in their management responsibilities in respect of health and safety. Neither appeared to know of the existence of monthly health and safety checklists which the store manager is supposed to complete. More widely, the evidence indicated that there was a lack of understanding within Hugo Boss about roles and responsibilities in terms of health and safety. 2) The second concern relates to the absence of regular health and safety audits by a suitably qualified health and safety professional. It was understood that Hugo Boss' new health and safety manager is to commence annual audits to check for compliance in the coming months. It seemed very likely on the evidence that a health and safety professional, particularly with knowledge of Hugo Boss store layout and fixtures and fittings, would have discovered the unsafe mirror.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation 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. I may extend the period on request. 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 the Interested Persons, including Austen's parents. The Chief Coroner may publish my report and your response 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Monday 13 April 2015** **Mr D. M Salter – HM Senior Coroner**