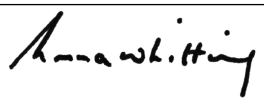
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Professional Light and Sound Association (PLASA)** Redoubt House 1 Edward Road Eastbourne BN23 8AS And **The National Rigging Advisory Council (NRAG)** [redacted], Chair Unusual Rigging Ltd The Wharf Bugbrooke Northamptonshire NN7 3QB E-mail: info.nrag@plasa.org
1	**CORONER** I am Emma Whitting, Senior Coroner for Bedfordshire & Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On Twenty-First March 2018 I commenced an Investigation into the death of Russell Paul BOWRY aged 52. The investigation concluded at the end of the inquest on Seventeenth October 2019. The medical cause of death was found to be: *Ia Hypoxic Brain Injury* *Ib Traumatic Cardiac Arrest* *Ic Multi-Trauma*

	The Conclusion of the Jury at the end of the Inquest was a **Narrative Conclusion** – **Accident with the following contributory factors:** **i) No written safe system of work** **ii) Russell Bowry's lanyard not being clipped on.**
4	**CIRCUMSTANCES OF THE DEATH** Russell Bowry's death was confirmed at 04:21 on 16th March 2018 following his admission to Addenbrookes Hospital on 13th March 2018 after a fall from height. Russell was an experienced, NRC level 2 self-employed rigger who had been contracted by ELP Broadcast and Events Ltd (ELP) to work on the construction of the roof for a stage set at Cardington Studios – the Studios occupies the whole of Cardington Shed 2, a hangar built of steel lattice construction in the early 20th century to accommodate airships. The hangar is not windproof or watertight and ELP (who is a member of PLASA) had been contracted by the producer of a West End musical to provide a 32m wide x 16m long x 10m high windproof, rainproof, cuboid stage within the hangar. To create the roof of the stage, ELP used an aluminium truss, of a kind which, I believe, is standard in your industry. The truss had two x 32m sides and eight x 16m transverse sections. It was to be permanently installed, for a period of months, through attachment to the steel lattice and existing infrastructure of the hangar. It was assembled at floor level and its topsides were covered in rockwool, which in turn were covered with black plastic save for along the two long sides, where only the rockwool (and not the black plastic) was installed at ground level. The black plastic was omitted along these sides to permit the attachment of the hoisting equipment to the truss. On 12 March 2018 ELP, assisted by NRC level 2 riggers including Russell, raised the said roof to a height of 9.5 metres on chain winch hoists and proceeded to attach it permanently to the steel lattice structure of the hangar. At the time of the fall, on the morning of 13 March 2018, Russell was working on the roof of the structure at a height of 11 metres. He was standing on one of the long sides of the truss attaching steel cables between the truss and the structure of the hangar. He was wearing a harness. Attached to the harness was a single lanyard. The lanyard was not attached to an anchor point. Almost immediately following a fall (with less serious consequences) of a fellow rigger, Russell fell a distance of 11m through the exposed rockwall material of the roof and sustained fatal injuries.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. On the evidence I heard, the system for carrying out this work at height was unsafe. Even if Russell Bowry's lanyard had been attached to the truss, he would probably have sustained some injury. Nobody, apart from him, checked his work equipment before he went up on the roof. There were points on the roof where riggers risked death or

	life-changing injury in the event of a fall, and yet no safe anchorage system had been designed or discussed with the individual riggers prior to the work commencing nor had the use of double lanyards been mandated and/or enforced. Whilst a rigger was wearing only a single lanyard, given that there was not a continuous overhead safety line in place, there were inevitably times when the rigger would not have been securely attached. I also heard evidence which suggested to me that such conditions are common in your industry. Although, I was provided with evidence from ELP to reassure me that ELP have since made changes to improve the safety of its working practices, in my opinion there is a risk that future deaths will occur in your industry unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (a) Employers in your industry may believe that they can safely delegate to individual riggers the responsibility to plan work at height, supervise it and carry it out safely. Russell Bowry was an NRC level 2 rigger but he was working directly under ELP, whose employees had no NRC qualifications. There was no head rigger. ELP gave evidence that it was their expectation that experienced riggers could be relied upon to ensure their own safety. Yet the riggers from whom I heard, told me that they were not always clipped on; (b) Employers in your industry may not realise they are responsible for designing the necessary safety features for work at height, including engaging the services of those who have the right skills to design such systems. Safe systems of work include ensuring that all clipping on points and safety features have the necessary impact requirements to hold a falling person and that the work can be done while the riggers are always clipped on or, that it is safe without clipping on; (c) Unsafe working practices are routinely encountered by riggers in your industry and due to the structure of your industry – in which a small number of employers engage a larger pool of self-employed riggers for individual jobs of short duration – riggers appear to have little influence over the fall protection or fall prevention measures that are put in place to keep them safe.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 29 December 2019. 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 the following Interested Persons: **Family of Russell Bowry, HSE, and ELP Broadcast and Events Ltd.** 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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 03 November 2019