REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **Federation of Piling Specialists:** Forum Court, Office 205, Devonshire House Business Centre, 29-31 Elmfield Road, Bromley, Kent, BR1 1LT. **Health & Safety Executive:** 900 Pavillion Drive, Northampton, NN4 7RG (Attention: Steve Hull). **Soilmec Limited:** New Lodge, Polebrook, Oundle, Peterborough, PE8 5LL.
1.	**CORONER** I am Peter James Bedford, Senior Coroner, for the coroner area of Berkshire
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** I conducted an Inquest into the death of the IP that was heard at Reading Town Hall between the 24th October and 2nd November 2016 before a Jury. The conclusion returned by the Jury was Misadventure.
4.	**CIRCUMSTANCES OF THE DEATH** The IP was a 24 year old man who was working on a building site in Maidenhead, Berkshire on 13th May 2014. In the course of pumping grease in order to tension the tracks on a piling rig, the grease nipple became detached and streams of grease under high pressure were expelled, striking the IP and causing fatal injuries.

Expulsion of the grease nipple had occurred the previous day and had been repaired by an external fitter.

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 this action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:-

(1) In the course of the evidence at the Inquest it was acknowledged that the risk of grease being expelled from the grease nipple at high pressure was recognised. No permanent warning plate or sign was attached to the machine beside the grease nipple.

(2) The grease nipple(s) of which there is one on each side of the machine was orientated on the piling rig so that it was perpendicular to, rather than parallel to, the tracks. This meant that the nipple faced out towards the greasing operator. Evidence suggested that other manufacturers have the grease nipple orientated parallel to the tracks.

(3) The evidence also given was that other piling rig manufacturers install pressure release values within the grease nipple unit that prevents pressure building up to the force that struck the IP.

(4) The Jury heard that, in the ordinary course of use of the machine, were covered by a metal plate. However, this had to be removed in order to carry out the greasing of the tracks. Evidence was given that new machines allow greasing of the tracks with the plate in place but there are a number of existing machines in use which do not have that adaptation.

(5) It is understood that no warning bulletin has been issued to existing users of the relevant piling rig machines warning of the risk of the grease nipple failure and potential consequences.

(6) It was heard that the manual for the piling rig is always kept in the cab of the machine for use by the operator. This was described as a 350 page manual. No quick reference condensed version of key matters is available.

(7) The manual does not contain a warning to always replace failed parts on piling rigs with new units. There is no statement that repairs or modifications to failed parts should not be carried out.

(8) The evidence suggested that certain piling rig workers were not following

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	the correct procedures for greasing the tracks suggesting that there was a training issue that needed to be addressed and possibly incorporated into the manual.
6.	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe your organisation has 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 13th January 2017. 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 family of the IP. You are 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 Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9.	**14th November 2016** **Peter J. Bedford** **Senior Coroner for Berkshire**