ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Carlsberg Supply Co Ltd**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Northamptonshire
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 16 November the coroner commenced an investigation into the death of David Chandler, age 45. The investigation concluded at the end of the inquest on 2 July 2018. The conclusion of the inquest was accidental death and the medical cause of death was inhalation of ammonia.
4	**CIRCUMSTANCES OF THE DEATH** On 9 November 2016 David Chandler was subcontracted to work at the Carlsberg Brewery in Northampton. He was employed by Speedrite NE as an engineer and was assisting with the removal of a dormant compressor unit. The compressor unit had not been used since previous work in 2014. At the time of the incident the compressor was isolated from the high pressure ammonia system on the discharge side using a single proved isolation. While Mr Chandler was assisting with the work a high pressure escape of gaseous ammonia occurred. Mr Chandler's three co-workers managed to escape but Mr Chandler died at the scene.
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 report to you. The **MATTERS OF CONCERN** are as follows. – (1) The isolation for the 2014 work was still in place and does not appear to have been reviewed in the intervening period. The 2014 work was of a different nature and did not require physical removal of the whole compressor. There does not appear to have been any formal review of the appropriate isolation standard for the work in November 2016 to be performed safely. (2) Carlsberg contracted the work to Crowley Carbon who employed specialist refrigeration engineers. The evidence at the inquest suggested that Crowley Carbon and Carlsberg were each relying on the other to ensure that the compressor was safely isolated. (3) The Permit To Work (PTW) issued by Carlsberg to allow Speedrite to remove the

	compressor made reference to the 2014 PTW isolation, was completed incorrectly, and made no reference to hazardous substances. (4) Relying on the isolation from previous work on the compressor appears to have caused confusion as to the safe level of isolation necessary for work of a different nature two years later.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st September 2018. 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: 1. [redacted] 2. Crowley Carbon 3. Empire Process Engineers 4. Speedrite International 5. Speedrite NE 6. Health and Safety Executive 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**5 July 2018** **Philip Barlow**