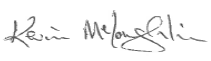
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hirst Electrical Plant Hire Services UK Limited, Unit 3, Mallard Industrial Estate, Horbury Junction, Wakefield, WF4 5QH.**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 22nd June 2020 I commenced an investigation into the death of Kenneth Audsley, aged 56. The investigation concluded at the end of the Inquest on Wednesday 8th September 2021. The conclusion of the Inquest was Accidental Death due to Carbon Monoxide Poisoning in the course of his work.
4	**CIRCUMSTANCES OF THE DEATH** Kenneth Audsley, aged 56 was an experienced high voltage electrical engineer. On Friday 19th June 2020 he was investigating a fault on a large industrial transformer at his place of work when he was overcome by carbon monoxide which had accumulated inside the transformer. The transformer should have been filled with 2500 litres of oil but in fact held only approximately 170 litres of oil. The carbon monoxide had collected in the space which should have occupied by the oil. The timescale and circumstances in which the oil was lost and the carbon monoxide gas collected in its place have not been established.
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 risk that a potentially lethal gas could accumulate inside the transformer was not appreciated either amongst the electricians in this workplace or those involved with industrial transformers generally. (2) There were no warning signs affixed to the transformer alerting users to the risk of using the transformer unless it had first been confirmed it contained adequate oil. (3) The manufacturer's manual contained no warnings of the hazard which would be created if the transformer were to be energised without containing adequate oil for cooling and insulating purposes. (4) The manufacturer did not recommend a periodic maintenance regime to confirm adequate oil remained in the transformer and have it replenished if necessary.

	(5) By virtue of these matters there exists the possibility that comparable transformers in service throughout the UK may contain insufficient oil to be operated safely and prevent an accumulation of potentially hazardous gases in the space thereby created. (6) The risks identified could affect anyone (1) dismantling a transformer at the end of its life; (2) having cause to open a transformer for repair or maintenance purposes or (3) users who maybe unaware that inadequate oil could cause a transformer to overheat or catch fire.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 Thursday 4th November 2021. 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) The family of Kenneth Audsley (2) The Health and Safety Executive, FAO [redacted] I have also sent it to the following who may find it useful or of interest: (1) Loadgen Limited, FAO [redacted] (2) [redacted], Power 2 Connect (3) RF Winder Electrical Limited, Belgrave Works, Town Street, Leeds (4) The Institution of Occupational Safety and Health (IOSH) (5) West Yorkshire Police, FAO DC [redacted] 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	Dated: Thursday 9th September 2021 Signed:  KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E)