	REGULATION 28 **REPORT TO PREVENT FUTURE DEATHS**
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** On 18th September 2019 the death of Mr Christian Kwame Tuvi [redacted], an escalator cleaner aged 44, in Waterloo Station was reported to the coroner by the British Transport Police. A forensic autopsy was conducted. An inquest was opened on 30th September 2019, and was suspended under CJA schedule 1(1). It was extended, due to the ongoing criminal investigation. On 1st March 2022, BTP informed the coroner that there were to be no charges and that the matter was then referred to the Office for Road and Rail. The senior coroner resumed his investigation. The inquest did not engage Article 2 ECHR. On 16th June 2023, the jury returned a narrative Record of Inquest The medical cause of death was 1a blunt force (crash) trauma to the chest 1b Movement of the travellator while Mr Tuvi was in the gap.
4.	**CIRCUMSTANCES OF THE DEATH** The jury concluded that there was an inadequate briefing to the cleaners, omitting the form of communication to be used, a failure to complete a site specific risk assessment, and a failure to give an audible warning that the travellator was about to be moved. The jury found that two other matters contributed to the death: failure of the person in charge to plug the inching pendant into the closest port to the gap being cleaned and an acceptance of variation and non-compliance with the established method statement not being corrected.

5.	**THE CORONER'S MATTER OF CONCERN** The ORR informed the coroner that in 2020 an improvement notice was served on Cleshar Cleaners, requiring them to provide a safe system of work for communicating the movement of the conveyor which does not rely solely on verbal communication. Cleshar has appealed the Improvement Notice and the Employment Tribunal have stayed the notice until 2024. Although the improvement notice is under appeal Cleshar has made some changes to improve their safe system of work. These included a padlock for the operative to place on the nearest isolator switch before entering the gap, pressing the stop button in, KONE discussing with Cleshar where the gap is to be left prior to handing over control of the machine and the risk assessment and method statement now identify the need for a middle person to relay messages. The improvements that Cleshar made have allowed them to resume the deep clean of Waterloo moving walkway. However, the TfL familiarisation training for working in a plant room no longer provides inching as part of the course. TfL expects their contractors to provide inching training for their operatives. Without the evidence of competence to inch the machine the isolation/inching function remains with KONE as a temporary solution. It is unclear why this cannot be a permanent solution. I heard from witnesses that it would be safer for engineers, who are present during deep cleans, to operate the movements of the travellator, but I was told that it would lead to a lack of clarity as to who was in charge. This seems not to be insoluble given different contractors with different employees is a norm on building sites working safely under HSE rules across the country. More likely there are undisclosed issues perhaps related to assumption of responsibility for risk or financial considerations which explain the resistance. The inquest heard that prior to the accident, cleaners would attend a TfL training course with a signed form which TfL observed was a certificate of competence to inch and operate the controls of the travellator. But the issuing manager and cleaners thought that the TfL course provided that training. The withdrawal of that training and the

inability to find another training facility, has led to the cleaners not being trained and so not permitted to operate the travellator.

Cleshar Cleaners management have not in the past assessed their cleaners for competence to inch and there is no agreed standard of competence. Concerns were expressed in the inquest that most of the cleaners did not have English as their first language and that the risk assessment method statement was a huge technical document, with which the cleaners were not familiar and they all required training in the whole method of work, and not just the person in charge.

MY CONCERN and reason for reporting this matter to the minister and not just the regulator and contractors, is that nearly four years have passed and there remains an impasse between the organizations as to whom should train whom, and the competence required to operate the travellator whilst it is being cleaned. It seems that TfL has the power to produce a resolution, but is leaving matters to others to resolve. It is hard not to conclude that there is corporate reluctance to assume risk for an important public service. The regulatory bodies and contractors in the supply chain have allowed this matter to remain unresolved for an unacceptable length of time and there may be a system failure in the allocation of responsibilities and powers in the process of contracting for cleaning escalators.

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This REPORT IS BEING SENT TO:

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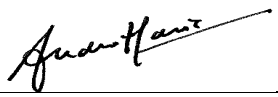
1. The Rt. Hon Mark Harper, The Secretary of State for Transport, Department of Transport, Zone 1/18 Great Minister House, 33 Horseferry Road, London, SW1P 4DR

2. [redacted], Chief Executive of Office for Road & Rail, 25 Cabot Square, London, E14 4QZ

7.	**ACTION SHOULD BE TAKEN** The public cannot be assured that the lessons have been learnt from this tragedy unless the redesigned improved system of work for cleaners is implemented with appropriate training and leadership in a permanent sustainable contracting system. These matters remain in dispute and may need political and regulatory enforcement.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by September 4th, 2023. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer, [redacted] and coroner paralegal, [redacted]
9.	**COPIES and PUBLICATION** The report is copied to Transport for London (TfL), Cleshar Cleaning Services Ltd (Cleshar) and Kone Plc. *as* these organizations need to know of the report to the Department and Regulator seeking review of the contractual process or directions to resolve the impasse between them, to ensure that a permanent solution is found that secures the minimization of risks of deaths in cleaning moving walkways and escalators. It is also sent to the other interested persons: [redacted] representing family from Simpson Millar Solicitors. [redacted] representing [redacted] from Keoghs Solicitors. I have sent a copy of my report to the following interested persons: [redacted] for Transport for London. [redacted] for Cleshar of BCL Solicitors LLP. [redacted] for Kone Plc from Walker Morris Solicitors. [redacted] for Office of Road and Rail. I will also be sending a copy of my report to British Transport Police for information.

	I am also under a duty to send the Chief Coroner a copy of your response. He 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.
10.	**[DATE]** **[SIGNED BY SENIOR CORONER]** **Monday 10th July, 2023**  **A N G Harris**