# **Regulation 28: Prevention of Future Deaths report**

Sean Patrick O'CONNOR (died 24.11.21)

	THIS REPORT IS BEING SENT TO:	
	1. Chief Executive Officer Canary Wharf Management Limited (CWML) One Canada Square Canary Wharf London E14 5AB	
1	CORONER	
	I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP	
2	CORONER'S LEGAL POWERS	
	I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.	
3	INVESTIGATION and INQUEST	
	On 2 December 2021, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Sean O'Connor aged 34 years. The investigation concluded at the end of the inquest on 1 May 2024. The jury made a determination at inquest of death by accident.	
4	CIRCUMSTANCES OF THE DEATH	
	On 24 November 2021, shortly after 10am, Mr O'Connor was electrocuted as a result of contact with a heat pump flow switch terminal, during the course of work at Columbus House 7 Westferry Circus, London. He was a Mitsubishi employee changing the flow switch.	
	His medical cause of death was: 1a electrocution.	

#### 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.

I heard evidence at inquest that, as he was regarded as a lone worker, Sean O'Connor could and, according to the risk assessment method statement (RAMS), should have asked a CWML colleague to come to check on him during the day. He did not ask for such a check and, although a CWML employee thought of doing so, that person was busy and so did not.

Whilst such a check is likely to have taken place too late in the day to have changed the outcome for Mr O'Connor, that might be different for another lone worker.

Several witnesses gave evidence that discussions take place with every worker coming on site as a matter of routine, covering such matters as where the worker is meant to be located, the exact nature of the job and so forth. The CWML director who gave evidence at inquest agreed with me that it would be a straight forward matter to include within that as a point always for brief discussion, whether any checks are required during the day. In this way, if the operative forgets to ask, the discussion can act as a reminder.

## 6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you 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 15 July 2024. 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 following.		
	<ul> <li>, wife of Sean O'Connor</li> <li>, parents of Sean O'Connor</li> <li>Mitsubishi Electric</li> <li>The London Borough of Tower Hamlets</li> <li>HHJ Thomas Teague QC, the Chief Coroner of England &amp; Wales</li> <li>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.</li> <li>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.</li> </ul>		
9	DATE	SIGNED BY SENIOR CORONER	
	08.05.24	ME Hassell	