




	<p style="text-align: center;">REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p style="text-align: center;">JOHN HENRY OATES known as HARRY OATES</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Electricity Networks Association</p>
1	<p>CORONER</p> <p>I am Miss Kirsty Gomersal HM Senior Coroner for County of Cumbria</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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:</p> <p>https://www.legislation.gov.uk/ukpga/2009/25/contents</p> <p>http://www.legislation.gov.uk/uksi/2013/1629/contents</p>
3	<p>INVESTIGATION and INQUEST</p> <p>Throughout the course of my investigation into Mr Oates' death, his family invited me to call him Harry. I shall do so throughout this Report.</p> <p>Harry died on 27 October 2023 in a field at Badger Gate, Lupton, near Carnforth in Cumbria.</p> <p>Following post-mortem examination, the medical cause of Harry's death was found to be:</p> <p>1(a) Electrocution</p> <p>An investigation into Harry's death was commenced on 31 October 2023.</p> <p>An Inquest into Harry's death was opened on 14 November 2023 by HM Assistant Coroner Robert Cohen. At the same time, Harry's Inquest was suspended in opening in accordance with Coroners and Justice Act 2009 Schedule 1 Part 1 Paragraph 5 pending the outcome of external agency enquiries.</p> <p>The investigation into Harry's death resumed on 19 July 2024 and his inquest was held before me on 9, 10 and 11 December 2025. I delivered my findings, determination and conclusion on 16 December 2025.</p> <p>The determination was:</p> <p><i>On 27 October 2023, Mr John Henry Oates, who was known as Harry, was on a training run. At approximately 14:07 Harry was running on a public footpath on a field at Badger</i></p>

	<p><i>Gate when he came into contact with a low hanging 11 kv electricity conductor. Harry was killed immediately. His death was confirmed at 1835.</i></p> <p><i>The conductor had been released from its usual position on 25 October 2023 at about 16:17 and became suspended on equipment lower down the pole. The conductor did not go to earth and remained live. At the time, there was no automatic means of detection of the low hanging line. The low hanging line had not been reported.</i></p> <p><i>The low hanging line was caused by the simultaneous failure of two porcelain tension disc insulators on 25 October. The root cause of the insulator failures was voids in the cement fill. Voids in the cement were not known at the time. These voids allowed internal electrical discharge. This caused the electrical failure of the first insulator. This failure led to the top cross arm becoming energised. This caused the second insulator to fail electrically and mechanically. The live conductor was released and suspended from the lower cross arm on the supporting pole. This sequence of events was rare and complex. It lead to the conductor become low hanging yet remaining energised.</i></p> <p>The conclusion of the inquest was:</p> <p><i>Harry died due to a rare and complex sequence of events</i></p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 27 October 2023, at about 11:50, Harry departed his parents’ home for a training run. Whilst crossing a field at Badger Gate, at approximately 14:07, Harry came into contact with a low hanging 11kv electrical conductor wire which had fallen from its usual height at over 8 metres at pole 660901. Harry was located at 16:S34 by his father and brother who raised the alarm. Emergency services and ENWL attended the scene. Harry had sustained injuries inconsistent with life. His death was instantaneous. Harry’s death was formally confirmed at 18:35.</p> <p>ENWL is the Distribution Network Operator (“DNO”) responsible to the electrical conductor.</p> <p>ENWL and HSE carried out an investigation into the incident. It was found that:</p> <p>On 25 October 2023 at approximately 16:17, there was a simultaneous failure of two porcelain tension disc insulators on pole 660901 in the field at Badger Gate.</p> <p>This caused the 11kv conductor wire to become released from its usual position. The length of the conductor wire was extended by the “dropper”. The conductor became suspended on a cross arm further down the pole hosting an Auto Sectioning Link.</p> <p>This resulted in a “low hanging line”. As the line did not go to earth, it remained energised.</p> <p>The fault on pole 660901 was detected as a “phase to phase” transient fault and automatically reconnected in accordance with ENWL procedure. At the time, a phase-to-phase fault was not known to lead to a low hanging line.</p> <p>Evidence was consistent that, at the time, there was no automated mechanism to detect a low hanging line and that electricity industry relied on low hanging lines being reported by members of the public. The low hanging line was not reported to ENWL until after the incident.</p> <p>As part of ENWL’s investigation into the incident, approximately 260 insulators were examined and tested. 73% of insulators were found to contain voids in the cement fill of the porcelain insulators. These voids were introduced during the manufacturing process. The presence of voids was not known until identified through ENWL’s investigation</p>

	<p>despite the insulators having been used throughout the electricity (and other) industries since the 1950s.</p> <p>The voids in the cement fill led to microcracking and subjected the cement to environmental factors. The voids and microcracking affected the cement integrity and created “air gaps” which permitted internal electrical discharge.</p> <p>Further, the investigation also found that a number of insulators had asymmetrical pins. I found that the insulators in question were likely to have asymmetrical pins as well as voids but it was not possible to determine the contribution of the asymmetrical pins to the insulator failure.</p> <p>The root cause of the insulators’ failure was voids within the cement fill.</p> <p>The first insulator failed electrically due to an internal flashover / short circuit. This caused the steel cross arm of the pole (to which the insulators were fixed) became energised. The second insulator consequently failed electrically and mechanically.</p> <p>The evidence was that whilst insulator failures were recognised, a double insulator failure had not been known to previously occur.</p> <p>The poles and insulators were inspected in accordance with procedures consistent with industry standards. There were no relevant concerns following the last inspection in August 2023. There were no visual signs that the insulators had a fault. There was no means of testing the insulators in situ at the time.</p> <p>The electricity conductor was above the minimum height required and that the pole span was within the maximum span permitted by the relevant British Standard. Placement of the supporting poles depends on a number of factors. The evidence of the HSE inspector was that the placement of the poles did not cause him concern.</p> <p>The failure mode was described in several ways by the witnesses including “first to our knowledge and not experienced before”, complex, unique, very unique, not known, unprecedented, rare and extremely rare.</p> <p>I determined that the failure mode, described above, was a rare and complex sequence of events which directly caused Harry’s death.</p> <p>I heard evidence of the steps that ENWL had and were taking as a result of its investigations:</p> <ol style="list-style-type: none"> 1. The use of porcelain insulators was stopped. 2. ENWL estimated that, within its network, there are approximately 8,000 locations where porcelain insulators are present above equipment affixed lower down the pole on which a conductor may become suspended. Where maintenance work is required at those locations, ENWL will replace the porcelain insulator. ENWL intends to embark on a replacement program but this requires liaison with OFGEM due to the extent of the work and outages required. 3. It is now recognised that a phase-to-phase fault can lead to a low hanging line; this was not the case prior to the incident. Although patrols were not required prior to Harry’s death, ENWL now carries out patrols of lines affected by a phase-to-phase fault within 48 hours. 4. ENWL will also consider the placement of support poles relative to a right of way in future. I did not find that the placement of the support poles was contributor to Harry’s death.
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5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <ol style="list-style-type: none"> 1. The cement fill within the porcelain tension disc insulators was found to contain voids in 73% of the insulators tested. These voids were introduced during the manufacturing process. The industry was unaware of these voids until discovered during ENWL's investigation. Porcelain tension disc insulators are used widely throughout the electricity industry – and other industries. 2. Some of the discs tested were also found to have asymmetrical pins which increased the internal stresses on the insulators. 3. Either voids alone or in combination with an asymmetrical pin create a means by which electric current can pass across the voids and lead to failure of an insulator. 4. There has now been a double insulator failure. 5. A phase-to-phase fault can lead to a low hanging line. This was not known prior to Harry's death. 6. There will be locations across the UK which have the combination of porcelain tension disc insulators situated above equipment (such as an ASL) on which a conductor could be suspended in the event of disc failure. 7. Although at the time of the incident, there was no automatic means of detecting a low hanging line, technology now exists that can detect both these factors and which narrows the area in which the low hanging line is situated – Linesight. 8. It has also been determined that Linesight can detect that an insulator may be subject to internal stresses. <p>Although the failure mode was "rare and complex", there is a risk of future deaths albeit a low one. This presents an opportunity for guidance to be given on re-assessment of risk and risk reducing measures. Although I determined that the placement of the support poles was not materially contributive to Harry's death, there is also an opportunity for this to be considered.</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe the</p> <p>Electricity Networks Association</p> <p>has the power to take such action.</p> <p>The ENA is the electricity networks industry representative and supports its members to deliver energy safely and share best practices. It has a Safety Health and Environment Committee and issues best practice to the industry.</p> <p>I again stress that the ENA was not an Interested Person in Harry's inquest. It did attend nor did it provide any evidence to me – and was not asked to do so.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 February 2026.</p> <p>I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>Harry's family ENWL (now SP Electricity North West) HSE</p> <p>I have also sent a copy to:</p> <p>OFGEM</p> <p>And the following DNOs:</p> <p>Scottish & Southern Electricity Networks SP Energy Networks Northern Powergrid UK Power Networks National Grid ESB Networks Manx Utilities Northern Ireland Electricity Networks</p> <p>Whilst I appreciate that ESB Networks, Manx Utilities and Northern Ireland Electricity Networks do not fall within the Coroner's jurisdiction, in my view, it is appropriate to bring this Report to their direct attention.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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.</p>

9	<p>Dated this 18 day of December 2025</p> <p></p> <p>Miss Kirsty J Gomersal LLB HM Senior Coroner County of Cumbria</p>