REGULATION 28: REPORT TO PREVENT FUTURE DEATHS(1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. The Department of Transport.
1.	I am Chinyere Inyama, senior coroner for the coroner area of East London.
2.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INVESTIGATION and INQUEST** On 30th May 2012 I commenced an investigation into the death of Kuldip Singh Dhillon then aged 57. The investigation concluded at the end of the inquest on the 20th September 2013. The conclusion of the inquest was accidental death and the medical cause of death being extensive full thickness burns.
4.	**CIRCUMSTANCES OF THE DEATH** 1. Essex Police were performing a rolling road block to clear debris off the M25 on the 25th May 2012. 2. Vehicles had slowed and stopped. 3. The deceased was driving a lorry when he (as confirmed by CCTV footage) collided into a stationery vehicle. 4. He was trapped in his vehicle when the vehicle exploded following the impact, engulfing his cab in fire. 5. He was confirmed dead at the scene.
5.	**CORONER'S CONCERNS** During the course of the inquest, evidence revealed matters giving rise

	to concern. In my opinion there is 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. Evidence was given at the inquest that the load which the deceased was carrying was sitting on the vehicle's load bed without any restraint at all. 2. This, according to the evidence given, was 'common practice nationwide with palletised loads'. You note that this evidence was given by a senior engineer from the Engineering Safety Unit of the Health and Safety Laboratory. 3. This type of lack of restraint not only puts a driver at risk whilst driving but also at risk during loading and unloading. 4. Evidence was given at the inquest by the senior engineer that similar evidence has been given be her at inquests nationwide over a number of years without any apparent change in industry practice. 5. Evidence was given at the inquest that it is the Department of Transport that is responsible for enforcing and auditing compliance with the pieces of legislation (supported by specific guidance and codes of practice) that govern the loading and transport of goods by road in the UK. 6. Evidence was given that there, clearly, is insufficient enforcing and auditing of the guidance and codes of practice.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you/or your organisation have the power to take such action. It is clear there should be a review of the systems in place that are meant to ensure there is no risk of anaphylactic shock in such cases. In addition, the operation of the system should be audited on a regular basis since potential consequences of absence of or poor operation of such systems are potentially so serious.
7.	You are under a duty to respond to this report within 56 days of the date of this report namely by 3rd December 2013. 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 Person – [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 of the publication of your response by the Chief Coroner.
9.	**8th October 2013.**