HER MAJESTY'S CORONER

for the county of West Yorkshire (Eastern District)

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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Director of Lightwater Quarries Limited, Potgate Quarry, 1. North Stainley, Nr Ripon, North Yorkshire CORONER 1 I am Melanie Jane Williamson, Assistant Coroner, for the coroner area of West Yorkshire (Eastern) 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. **INVESTIGATION and INQUEST** On 19 March 2012 I commenced an Investigation into the death of ADRIAN JOHN PICKARD ("the Deceased") then aged 29 years. The Investigation concluded at the end of the Inquest on 20 November 2013. The conclusion of the Inquest was 'Narrative', the cause of death being:-1a) Multi organ failure 1b) Severe chest and abdominal injuries 1c) Road traffic accident CIRCUMSTANCES OF THE DEATH On the 7th March 2011 the Deceased commenced employment with Lightwater Quarries Limited ("the Company") as a Quarry Operative and Truck Driver from premises situate at North Stainley, near Ripon. The Company was the owner of Scania large goods vehicle with volumetric cement mixing capacity, registration number MV03 GFU ("the Vehicle"). During the early morning of the 17th February 2012 the Deceased drove the vehicle from the Company's premises. The vehicle was laden with gravel, sand and water. The weighbridge operator employed by the Company could not recall whether, on this date, the vehicle was weighed prior to its departure from the Company's premises. According to the Chairman of the Company, the Company's cement mixing vehicles are not always weighed before they leave the said premises and they may, therefore, exceed their gross legal weight. In the course of the Deceased's journey, whilst negotiating a bend, the vehicle overturned thereby causing the Deceased to sustain traumatic injuries from which he died at 1659 hours on the 26th February 2012 at St James's University Hospital in Leeds. At the time of the incident, the vehicle was in an un-roadworthy condition and was travelling at an inappropriate speed.



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) That not all of the Company's vehicles, which vehicles travel on the public highway and are laden with e.g. aggregates, are weighed on each occasion prior to their departure from the Company's premises. ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. In my opinion, the Company should ensure that all its goods vehicles, including volumetric cement mixers when laden, should be weighed prior to their departure from the Company's premises. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 February 2014 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. COPIES and PUBLICATION 8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - DAC Beachcroft Claims Ltd, Irwin Mitchell Solicitors, Dyne Solicitors Ltd, Family of the Deceased and 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.

31 December 2013

Miss Melanie J Williamson

Assistant Coroner