REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] HM Principle Specialist Inspector (Mechanical Engineering)** **2. [redacted] Chairman, British Industrial Truck Association MHE/7** **3. [redacted]**
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner, for the coroner area of South Yorkshire (East) District.
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.
3	**INVESTIGATION and INQUEST** On 21st June 2013 I commenced an investigation into the death of Elizabeth Joy Turnbull, age 65. The investigation concluded at the end of the inquest on 20th January 2014. The medical cause of death was 1a Hypoxic Brain Injury (clinical), 1b Cervical spine injury with tetraplegia and multiple chest fractures, 1c Mechanical crush trauma. The short form conclusion of the Jury was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On the 8th June 2013 Elizabeth Joy Turnbull was helping her husband repair a stock fence when the bucket attached to the end of a telehandler being used to drive the fence posts in dislodged from the clevices and fell onto Mrs Turnbull. She died on the 15th June 2013 due to injuries sustained as a result of crush trauma.
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. – (1) The layout of the thumbwheel controls namely one immediately above the other, the first controlling release of locking pins which secure buckets and attachments, and the second thumbwheel used to move the telescopic arm backwards and forwards. (2) The absence of any dual controls which would both have to be activated before the pins could be released. (3) Due to 1 and 2 above the ease at which the user could inadvertently release locking pins rather than moving the telescopic arm
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 Friday 21st March 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner. 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.
9	**24th January 2014** **Ms N J Mundy**