



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Managing Director Wayland Farms Limited Little Melton Food Park Beckhithe Little Melton Norwich NR9 3NP</p> |
| 1 | <p>CORONER</p> <p>I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK</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> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 26 March 2015 I commenced an investigation into the death of PETER JOHN BUCKLE, AGED 67 YEARS. The investigation concluded at the end of the inquest on 29 OCTOBER 2015. The conclusion of the inquest was Medical Cause of Death: 1a) Traumatic Subarachnoid Haemorrhage b) Hinge fracture of skull. Conclusion: Misadventure.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>On 24 March 2015, whilst at work, Mr Buckle was instructed to load rubbish onto his trailer. The telehandler was not working so it was suggested the rubbish was to be thrown into the trailer by hand. It was then felt the sides of the trailer were too high. It was decided to prop open the tailgate with a post. A post was propped against the tailgate but it slipped causing the tailgate to fall resulting in injury to Mr Buckle. He was airlifted to Addenbrooke's Hospital where he died later that day from his injuries. Health and safety procedures were in place at the time of the incident and since the incident a "Stop and Think" campaign which had been identified earlier, has been put in place.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>(1) Although a risk assessment was in place for the original method of carrying out the task (with the telehandler and grab), once this method was no longer viable a risk assessment was not carried out or considered prior to steps being taken with regard to the next method under consideration, namely to throw the rubbish over the side of the trailer; in that the trailer was reversed to the rubbish site, a telephone call was made to 2 other employees to assist and protective equipment was being obtained. This left Mr Buckle to assume the work was to be carried out in this way, whether or not the Site Manager was of the view the method of work was still under consideration. In any event this method of carrying out the work was blatantly unsafe.</p> <p>(2) The employees left at the site of the rubbish, decided on a third method of carrying</p> |

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| | <p>out the work, without any thought for health and safety. Although health and safety induction training had been undertaken and managers had received further training, a health and safety culture was not apparent from the evidence, particularly at "ground level".</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</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 31 December 2015. 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>  (via Thompsons Solicitors) Health & Safety Executive (Paul Unwin) RoSPA </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. 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.</p> |
| 9 | <p>3 November 2015</p> <p style="text-align: right;">  Jacqueline Lake Senior Coroner for Norfolk </p> |