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:** Maurice Mason Ltd, Fincham, King's Lynn, Norfolk PE33 9DQ
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK
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 10 JULY 2014 I commenced an investigation into the death of ARTHUR CAXTON MASON, AGED 21 YEARS. The investigation concluded at the end of the inquest on 18 MARCH 2016. The conclusion of the inquest was medical cause of death: 1a) Asphyxiation and short-form conclusion: ACCIDENTAL DEATH
4	**CIRCUMSTANCES OF THE DEATH** On 9 July 2014 Mr Mason was cleaning the inside of a grain bin at Hall Farm, Fincham, King's Lynn, Norfolk. He was standing on moving grain whilst his colleague went to close the hatch shutter. When he returned Mr Mason was beneath the grain. Following attempts to rescue Mr Mason by colleagues and emergency services, his body was recovered through an access hatch and he was pronounced dead at the scene.
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) As at July 2014 no member of staff had undergone training in respect of assessing risks and carrying out Risk Assessments. Following Mr Mason's death, one member of staff involved in risk assessments has undergone training. This member of staff is involved in the administration side of documents. Other, senior, members of staff involved in carrying out risk assessments have not undergone any such training and from the evidence did not appear to fully accept risks as set out in Health & Safety Executive documentation, preferring to rely on their own "experience and common sense".

	(2) It was unclear from the evidence that staff involved in carrying out Risk Assessments recognised the risks of carrying out various tasks on the farm. The current document "Procedure for Cleaning out Grain Bins" does not recognise any risks or hazards in carrying out the tasks and it was not clear from the evidence a Risk Assessment is in place for this new procedure, introduced following and as a result of Mr Mason's death. (3) The "what to do in an emergency" Sheet in place as at July 2014 contained a list of persons to contact and telephone numbers and coordinates to pass to emergency services. There was no Emergency Plan in place. This has not changed following Mr Mason's death. Although the grain bins are not to be entered by any personnel on cleaning, it was clear from the evidence, there are other hazardous areas on the farm. These "Emergency Sheets" are currently in use and there is no plan or procedure in place for employees to follow should another emergency occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 27th May 2016. 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 Persons: [redacted] Health & Safety Executive I have also sent it to: RoSPA – who may find it useful or of interest 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	**1 April 2016** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**