REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. [redacted] Managing Director, MAC Skip Hire Limited, Ventura House, Ventura Park Road, Tamworth B78 3HL

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of Rutland and North Leicestershire

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 9th November 2015 I commenced an investigation into the death of Beverley Dorothy Upton. The investigation concluded at the end of the Inquest with a jury on 1 September 2016. The conclusion of the inquest was:

The Cause of death was:

1.a. Chest Injuries

The Conclusion of the jury was:

Accidental death

CIRCUMSTANCES OF THE DEATH

Mrs Upton was a heavy goods vehicle driver employed by MAC Skip Hire Limited (MAC). On the 4th November 2015 she was at work at the MAC premises in Hinckley. Her lorry was in the process of being loaded by a CAT Loading Shovel. During the course of the loading a carpet became lodged over the near side of the lorry. The driver of the shovel attempted to cut the carpet using the bucket of the shovel, moving it from side to side on the top edge of the nearside of the lorry. That was unsuccessful. Mrs Upton got out of the cab of her lorry and tried to help to drag the carpet down, again unsuccessfully. She was not wearing any high visibility clothing.

On three occasions the driver of the shovel put the bottom edge of the bucket on the carpet, putting the bucket into a vertical position, attempting to drag the carpet towards him. On the last occasion his evidence was that he saw Mrs Upton move towards her lorry cab and gave him the "thumbs up". During the last manoeuvre Mrs Upton was trapped between the bucket and the side of the truck, and died as a result of injuries sustained.

It was apparent from the evidence given at the Inquest that:

1. The driver of the CAT Shovel had not seen Mrs Upton as he approached the side of her lorry on the last occasion;

2. His view of her and the lorry was restricted by the height of the bucket in front of him;

3. That his ability to have seen her may have been reduced because she was not wearing high visibility clothing;
4. There was a rule, apparent in the industry, stipulating that a driver should not

get out of their lorry whilst it was being loaded;

5. There was no written rule at MAC requiring drivers to stay in their cabs whilst loading;

6. There was no enforcement of the rule as to the use of high visibility clothing;

7. There was no enforcement of the rule that drivers should not get out of their cab;

8. Mrs Upton did get out of her cab, appears to have moved down the nearside of the lorry, and was trapped as indicated;

9. There was a lack of attention given to the drafting of health and safety documentation, with people preparing documentation who did not have appropriate training and experience in doing so;

10. There was insufficient training given to the staff of MAC in the nature of risk and the ways to reduce risk, as well as health and safety matters.

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 method of work employed at the time, in operating the CAT Loading Shovel to load lorries, put anyone in the vicinity at risk of injury or death
(2) There was no clear written guidance requiring drivers to stay in their cabs during loading, with sanctions if the rule was disobeyed
(3) There was no enforcement of the industry rule that drivers should not get out of their cab
(4) There was no enforcement of the rule that workers should wear high visibility clothing
(5) There was need for proper training to be given to those people whose task it was to assess risk, draft health and safety documentation, and who provided training to staff on risk and health and safety matters
(6) There was an urgent need for appropriate training to be given to staff of MAC into awareness of risk and health and safety matters

ACTION SHOULD BE TAKEN:
A detailed investigation should be undertaken into those matters that are set out in this letter, and urgent attention given to the assessment of risk. Appropriate steps then need to be taken to deal with and correct the deficiencies in the approach to health and safety and the methods of working.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd November 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
Mr Steven Newham and Melanie Upton and their solicitors Bray and Bray

DWF solicitors
The Health & Safety Executive
[redacted] Leicestershire Police

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.

7th September 2016 **Robert Chapman** **[SIGNED BY CORONER]**