

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Chief Executive of Health and Safety Executive, Director for England of the Forestry Commission, Chief Executive of the Arboricultural Association.</p>
1	<p>CORONER</p> <p>I am Alison Mutch ,Senior Coroner, for the Coroner Area of South Manchester</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 24th November 2016 I commenced an investigation into the death of Paul Anthony Daniels .The investigation concluded on the 30th November 2017 and the conclusion of the jury was one of accidental death. The medical cause of death was; 1a) Multiple Injuries.</p>
4	<p>Mr Daniels died on 23rd November 2016, time of death 14:30pm, at Wythenshawe Hospital. Mr Daniels was an experienced tree surgeon. On 23rd November 2016 Mr Daniels was working at Hazel Grove Golf Club. Mr Daniels fell approximately 50ft from a conifer tree, whilst carrying out the work. Mr Daniels life line and flip line were not attached in correct positions, resulting in him being pulled from the tree.</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> <ol style="list-style-type: none"> 1. There were two tree surgeons climbing with one groundsman between them. The ratio of 2:1 meant that the tree surgeons did not have someone supporting them and available immediately at all times; 2. The groundsman supporting the tree surgeons was not qualified for aerial work. This meant that should the tree surgeon have required assistance whilst in the trees the groundsman could not have gone to their help;

	<p>3. Communication between the groundsman and tree surgeons was via shouting and hand signals. This was difficult given the density of the trees being cut and the height that the tree surgeons were working at.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have 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 27th February 2018. 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 namely; 1) [REDACTED], mother of the deceased 2) Hazel Grove Golf Club 3) [REDACTED] who may find it useful or of interest.</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>Alison Mutch OBE HM Senior Coroner 02/01/2018</p> 