	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] (Haulage Contractors) Ltd 2. [redacted] 3. Health & Safety Executive 4. [redacted] 5. [redacted] 6. Chief Coroner
1	**CORONER** I am Mrs Joanne Lees, Assistant Coroner, for the coroner area of North Wales (East & Central).
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 7/2/17 I commenced an investigation into the death of Austin Allen Ellsum THOMAS. The investigation concluded at the end of the inquest with a Jury on 25th October 2018. The conclusion of the Jury was a short form conclusion of accidental death.
4	**CIRCUMSTANCES OF THE DEATH** On 6/2/17 the deceased was at his place of employment at a paper mill in Deeside and was walking on the factory floor when he was hit by a volvo shovel loader truck sustaining fatal injuries. The accident scene was attended by paramedics, North Wales Police including the road scene collision team and the Health & Safety Executive. The driver of the shovel loader truck was later arrested by the police. He was not charged with any criminal offences. Following interview, the driver provided a sample of blood for analysis which showed positive for cannabis. The inquest heard expert evidence during the inquest as to what, if any extent the driver was impaired. The experts conclusion was that whilst they could not say that the drivers ability was impaired they could say that the cannabinoids in the drivers blood 7 hours after the incident was not consistent with his admitted use. The jury were directed accordingly.
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) I heard evidence from an expert vehicle examiner who upon examination of the volvo shovel loader truck involved in the fatal accident found a CD in the CD compartment within the drivers cab of the truck. This CD player allowed CD's to be played to a volume level of 32. I heard no evidence as to when the CD was last listened to however, I am concerned that there exists an inbuilt facility for drivers to listen to music at high levels when operating heavy machinery in a confined space such as the warehouse. Whilst I heard evidence that a new radio communication system would cut out any music playing in the truck cab I am concerned that the levels of volume are such that they could provide

	a distraction for a driver. I also heard evidence that whilst instances of pedestrians and vehicles moving on the factory floor at the same time had been significantly reduced, it had not been eliminated altogether. The combination of a driver being distracted listening to music in an contained environment where heavy machinery is being operated presents a risk of future deaths. Whilst neither the existence of the CD player nor the playing of any CD was involved in this inquest, having raised the concern at the end of the inquest, no policy or working rules or regulations relating to the listening of music and or CD's whilst operating machinery for employees at the paper mill factory or any factory owned and operated by Downtons or UPM was brought to my attention. I make it clear that this issue played no part in the inquest of the deceased. (2) The inquest heard evidence as to the levels of cannabis in the blood of the driver of the shovel loader truck some 7 hours after the fatal incident. No evidence was available as to the levels of cannabis in the drivers system at the time of the fatal incident. The inquest heard evidence from the driver himself as to his cannabis use which included an admission that he had smoked cannabis on his own evidence the night before commencing an early shift the following day. The inquest also heard evidence that the drivers admitted use of cannabis was not consistent with the levels detected in his blood. I have been provided with a drugs policy from the factory operator which provides for drug testing on a 'show cause' basis only. There is no policy in relation to random testing particularly for drivers operating heavy machinery. Given the evidence heard at the inquest I am concerned that an employee may use drugs without the knowledge of his employer and continue to operate heavy machinery creating a risk of future deaths. I note that the policy I have been provided with does not appear to have been reviewed or updated following the incident resulting in the death of Mr Thomas in February 2017.
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 16/1/19. 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], [redacted], the Health & Safety Executive, [redacted] and [redacted], father of the deceased. 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	**<u>Mrs Joanne M. Lees</u>** **<u>Assistant Coroner</u>** **<u>North Wales (East & Central)</u>** **20/11/18**