REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HM Acting Chief Executive of Health and Safety**
1	**CORONER** I am Heath Westerman, Assistant Coroner, for the Coroner area of Cheshire.
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 8th March 2017 an investigation was commenced into the death of Mark Keith PARRY dob 14th March 1980. The investigation concluded at the end of the inquest on 18th March 2019. The conclusion of the inquest jury was that the deceased had died whilst undertaking repairs on a heavy goods vehicle when he was struck on the head by a piston from an exploding airspring which led to brainstem (duret) haemorrhage. The jury determined that the deceased had died by accident.
4	**CIRCUMSTANCES OF THE DEATH** Mark Keith Parry was a specialist heavy goods vehicle mechanic. On 21st February 2017 he was called out to a broken down heavy goods vehicle in Nantwich. He identified the cause of the breakdown as a broken trailing arm on axle 3, the rear most axle on the trailer unit. He crawled underneath the trailer unit in order to strap the trailing arm on axle 3 to axle 2 so that the HGV could be driven to a yard for repair. He exhausted the air supply out of the airbag to axle 3 but had not done so with the air supply to the airbag on axle 2. Whilst the strap was attached to axle 3 and axle 2 it was not secured tight as the ratchet clasp used to do that was open leaving the strap lose and baggy. Mr Parry was getting out from underneath the trailer unit using his legs first, his upper body and head being raised between axle 3 and axle 2, when an explosion occurred and the bellow from axle 2 was ejected and struck Mr Parry on the back of his head. He was transferred by air ambulance to the Royal Stoke University Hospital where he died on 2nd March 2017 from the unsurvivable head injuries received.
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. **Guidance** That there are no published guidelines by the Health and Safety Executive to mechanics and those companies that employ mechanics on how to work with or approach working with Air Suspensions on Heavy Goods Vehicles. The value of such guidance is that it would signpost strategies and risks attached to such work.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 14th May 2019. 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]. 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	**19th March 2019** **Heath Westerman** **Assistant Coroner, Cheshire**