ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Bailey Trailers Limited**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 5 October 2021, I commenced an investigation into the death of Aaron Darie James Fretwell, aged 19. The investigation concluded at the end of the Inquest on Friday 1 October. The conclusion of the Inquest was 'Accidental Death', with the following medical cause of death: **1a) Hypoxic Cerebral Encephalopathy** **1b) Cerebellar Herniation** **2) Lung Contusion**
4	**CIRCUMSTANCES OF THE DEATH** On 2 February 2021, Aaron Darie James Fretwell was working on the family far. In the curse of replacing a worn ring on an agricultural trailer, he raised the trailer body and disconnected the hydraulic services. Whilst working under the trailer body, it descended, tapping him against the chassis, causing him to sustain crush injuries from which he died on 3 February 2021.
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. No propping device was fitted to the trailer, which is understood to have been manufactured by Bailey Trailers Ltd in about 2002. 2. No warning signs were affixed to the trailer directing that the trailer body should be propped before anyone worked underneath it. 3. Trailers manufactured by 2002 should have complied with BS EN 1853: 1999 and/or the supply of machinery (Safety) Regulations 1992 which required a mechanical support to be installed to facilitate maintenance work to be carried out safely.

	4. Evidence taken at the Inquest indicated that many types of agricultural trailers were in use without such propping devices or warning signs, which gives rise to concern that comparable accidents could occur in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd December 2021. 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: • The family of Aaron Darie James Fretwell (deceased) • [redacted], Health and Safety Executive I have also sent it to who may find it useful or of interest: • National institute of Agricultural Engineers • British Agricultural and Garden Machinery Association 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	5th October 2021 *Kevin McLaughlin*