ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. SE Galvanisers Ltd** **2. PCRSteel Ltd** **3. [NAME]**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner/area coroner/assistant coroner, for the coroner area of Essex
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 [DATE] 4 April 2019 I commenced an investigation into the death of Christopher Sparks aged 47 years. The investigation concluded at the end of the inquest on 17 November 2020. The conclusion of the inquest was that Christopher Sparks died as a result of an Accident. The medical cause of death was 1a) blunt force trauma to the head.
4	**CIRCUMSTANCES OF THE DEATH** On 4 April 2019, Mr Sparks, who was employed by SE Galvanisers Ltd, was the driver of a HGV collecting a steel balcony frame from PCR Steel Ltd in Chadwell St Mary. During the loading of the structure the frame fell and struck Mr Sparks who at the time was on the trailer bed.
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 could 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) Ahead of the incident, there was no approved, safe loading and lifting plan in place and agreed between the two firms (2) PCR had not assigned a banksman to supervise the safe loading. Especially in the loading of loads of such weight and size as the balcony frame, there should be a banksman employed (3) There was no clearly marked designated area established where a lorry driver can be visible at all times. The deployment of cones and signage would have assisted. (4) PCR Steel did not have available, from the design stage onwards, the correct equipment to move safely and load the products they manufacture.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 8th January 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 – Mr and Mrs Sparks, Christopher Sparks' parents I have also sent it to the Health and Safety Executive who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**24 November 2020** **HMSC Mrs Caroline Beasley-Murray**