Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Lincs Firewood Co Ltd and DD Dodds and Son Ltd The Plantation Rowdyke Wyberton Boston PE21 7AQ
1	**CORONER** I am Jacqueline Lake, Senior Coroner for the coroner area of Norfolk
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 30 October 2020 I commenced an investigation into the death of Zachariah Nathaniel RICHARDSON aged 18. The investigation concluded at the end of the inquest on 23 September 2022. **The medical cause of death was:** 1a) Compression Asphyxia 1b) 1c) 2) **The conclusion of the inquest was:** Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Richardson started working for Lincs Firewood on 6 October 2020. He completed a two day practical and theoretical training course on operating forklift trucks (FLTs) on 18 October 2020. On 24 October 2020 Mr Richardson went to DD Dodds and Son's Elm Farm Site to help tidy up the site. He was alone from approximately 15.51 hours until 17.13 hours. At approximately 17.16 hours Mr Richardson was found trapped between a FLT and a wall. Mr Richardson suffered fatal injuries and was declared dead at the scene.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. Evidence was heard at the inquest that Mr Richardson, aged 18 years, had joined Lincs Firewood some 18 days prior to his death and had undergone training to use a FLT some 6 days prior to his death. He was left alone on a site for approximately 1 hour 20 minutes, which he had visited on one occasion a few days prior to his death. 2. The evidence was that the FLTs at the Elm Farm site were seven months overdue for the annual Thorough Examination and had not undergone a service since February 2019. The seat safety switch device on the FLTs had been defeated at some point prior to the incident. The seat safety switch device on one of the FLTs was defective 3. Evidence was heard at the inquest that a Health and Safety Consultant visited the sites at Lincs Firewood and Dodds and Son in October and November 2020, following Mr Richardson's death. The Consultant found there was little understanding of the importance of health and safety because there were no systems in place although working on high risk machinery. The perception of risk was found to be "*poor*" and "*no one had taken the time or understood the importance to become competent in health and safety prior to the incident*" 4. As at the time of making the Report in September 2021, no feedback had been received disagreeing with or challenging any of the findings in the Report 5. An email dated 11 November 2020 from Boston District Council to Health and Safety Executive referred to a visit made to the site that day which found "*Refusal to accept the nature of the goods in the yard presents a leptospirosis risk but agreed to issue pocket cards!"* and "*Some doubt as to the interpretation of the LOLER regs"* [which applied to the use and operation of the machinery on site]. 6. As at the date of the inquest, some 23 months following Mr Richardson's death, no evidence was heard as to any changes which had been made with regard to health and safety at either Lincs Firewood or DD Dodds and Son
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 November 21, 2022. 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], Parents Breckland District Council I have also sent it to Health and Safety Executive Boston District Council RoSPA 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 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 by the Chief Coroner.
9	**Dated: 26 September 2022**  **Jacqueline LAKE** Senior Coroner for Norfolk Norfolk Coroner Service County Hall Martineau Lane Norwich NR1 2DH