REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Mark Harper MP, Secretary of State for Transport** **2. [redacted] Wife of the Deceased** **3. Health and Safety Executive** **4. Titan Containers Limited** **5. Chief Coroner**
1	**CORONER** I am Dr. Peter Harrowing, LLM, Area Coroner, for the coroner Area of Avon
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 29th September 2021 I commenced an investigation into the death of Mr. Karl Mitchell age 50 years. The investigation concluded at the end of the inquest on 23rd March 2023. The conclusion was that the medical cause of death was I(a) Cerebral oedema; 1(b) Hypoxic brain injury; 1(c) Traumatic crush injury to chest, and the conclusion of the jury as to the death was 'Accident'

4	**CIRCUMSTANCES OF THE DEATH** The Deceased was a lorry driver with Titan Containers Limited a company who provided shipping type containers to various sites which were then used for storage and as temporary site facilities. The containers were loaded and off loaded using a lorry mounted crane. The lorry used by the Deceased was fitted with a hydraulic stabiliser beam and swing-up (rotating) hydraulic stabilising leg at each corner. These were deployed during the loading and off loading procedure so as to stabilise the vehicle whilst the crane was in use. On 23rd September 2021 the Deceased was delivering a container to a local primary school for the purposes of temporary storage during building works. The Deceased successfully off loaded the container and was in the process of retracting the nearside front stabiliser beam when he was crushed by the swing up (rotating) leg causing him to suffer a cardiac arrest. The fire and rescue services attended and he was released using the 'jaws of life'. He was attended by paramedics and conveyed to hospital where he died on 25th September 2021 as a result of his injuries. On this particular vehicle the control panel for the stabiliser beams and legs was mounted on the front nearside of the vehicle adjacent to the lorry mounted crane. In order to stow, in this case, the nearside stabiliser beam for road use it is necessary to rotate the swing up leg through 180° from the downward position to the vertical position. This enables the beam and leg to be stowed behind the cab of the vehicle when it is being driven on the road. Whilst carrying out this procedure the operator, in this case the Deceased, stands at the control panel with their back to retracting beam and leg. The swing up leg on the nearside when rotating upwards rotates in anticlockwise direction. Therefore the leg rotates directly behind the operator standing at the control panel. Whilst carrying out this procedure the Deceased was unaware that the swing up leg had not rotated fully to the upright position but was at an angle of approximately 80° from the downwards position. Therefore as the beam continued to be retracted the swing up leg crushed the Deceased against the control panel. Whilst further retraction of the beam could be stopped the hydraulic pressure remained trapping the Deceased and causing crush injuries.

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) There are a large number of these lorry mounted cranes with such stabiliser beams and rotating legs in use by companies of all sizes and for a variety of uses within the industry. (2) Whilst manufacturers have taken steps to modify the design of the stabiliser beams and rotating legs so as to ensure the risk of such crush injuries can be avoided in the future such modifications will only apply to new vehicles and those where the owner / operator of the vehicle becomes aware of possibility of modifications being available. (3) Vehicles without being modified will continue to be used throughout the industry and thereby such vehicles will continue to pose a risk of crush injuries occurring to the operator. (4) Action needs to be taken to disseminate the learning from this tragic incident throughout the industry so that operators of such vehicles are aware that safety modifications may be available for their vehicle and in any event operators need to be made aware of the risk of crushing so as to ensure safe operation at all times.
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 10th July 2023. 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 [redacted], wife of the deceased, Titan Containers Limited, and the Health & Safety Executive. I shall send a copy of your response to [redacted], wife of the deceased, Titan Containers Limited, and the Health & Safety Executive. I have sent a copy of my report to the Chief Coroner. 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	**22nd May 2023** **HM Area Coroner**