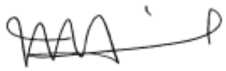
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Technical manager of ALLMI**
1	**CORONER** I am Jacqueline Devonish, Senior 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 04 March 2021 I commenced an investigation into the death of Michael HARRISON aged 42. The investigation concluded at the end of the inquest on 10 June 2024. The conclusion of the inquest was that: Misadventure
4	**CIRCUMSTANCES OF THE DEATH** Michael Harrison was a driver for a scaffolding firm. On 26 February 2021 he was working at Victoria Mills, Macclesfield Road, Holmes Chapel. Whilst unloading scaffolding from a Hiab truck the Hiab arm (a crane-like device) came down on him, causing crushing injuries which proved fatal. The jury found that he was wearing the remote control over his head and across his chest causing the inadvertent movement of the crane arm. The remote control had not been isolated during the unloading activity
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: During the course of the inquest it was evident that the HIAB design had no obvious audible sound when the crane arm was being operated by Mr Harrison. When giving evidence the 3D Scaffolding managing director stated that in a review of the safety of the remote control and risk of inadvertent operation of the crane in similar circumstances, he had subsequently made a written request for an audible sound and consideration of a two-handed remote operation design.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 08, 2024. 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] **HSE** **Cheshire Constabulary** **Representing 3D Scaffolding** I have also sent it to 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: 14/06/2024**  **Jacqueline DEVONISH** **Senior Coroner for** **Cheshire**