




Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Health and Safety Executive</p>
1	<p>CORONER</p> <p>I am Jacqueline DEVONISH, Senior Coroner for the coroner area of Cheshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 10 December 2020 I commenced an investigation into the death of Tony WILLIAMS aged 45. The investigation concluded at the end of the inquest on 15 July 2024. The conclusion of the inquest was that the death was a Misadventure.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 2 December 2020, Tony Williams, an HGV driver for ██████████, was delivering bales of hay to ██████████ in Cheshire. Thirty-three hay bales were loaded onto the 45ft HGV at ██████████ in Suffolk by the farm director in the presence of Mr Williams, who was experienced in the strapping and loading of Hesston bales. Three bales were loaded width ways, the opposite direction to the rest of the bales, on the back end of the vehicle.</p> <p>On the journey from Suffolk, somewhere along the route an ANPR camera had caught an image of hay overhanging the back of the vehicle. When arriving at ██████████ with the assistance of a banksman, Mr Williams reversed down ██████████ a public domain road with a known slope comparable to a wheelchair ramp. Mr Williams was witnessed by a Farmhand unstrapping the load when the three width ways bales fell from the back. Two of which fell on top of Mr Williams.</p> <p>The Farmhand who witnessed the unstrapping, removed the bales from Mr Williams with his telehandler and administered CPR with guidance from the ambulance service operator. When the ambulance arrived advanced life saving measures were administered to no avail. He was pronounced dead at the scene at 11:01 hours.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: The configurations for safely loading bales widthways, on a slope of 4.5 degrees and utilising crisscross strapping were considered in evidence. HSE produced laser measurements and images identifying the centre of gravity and risks associated with unloading overhanging bales on a slope when the most rearward bales are loaded widthways. HSE concluded that the accident would not have occurred if Mr Williams had not unloaded with the overhang facing downhill.</p>



	<p>It became apparent that there were no clear images in the guidance or support materials produced by HSE to assist drivers who load and unload bales.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by September 10, 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>I have also sent it to Mr William's family, Liverpool University, [REDACTED] [REDACTED] and [REDACTED]</p> <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 18/07/2024</p> <p></p> <p>Jacqueline DEVONISH Senior Coroner for Cheshire</p>