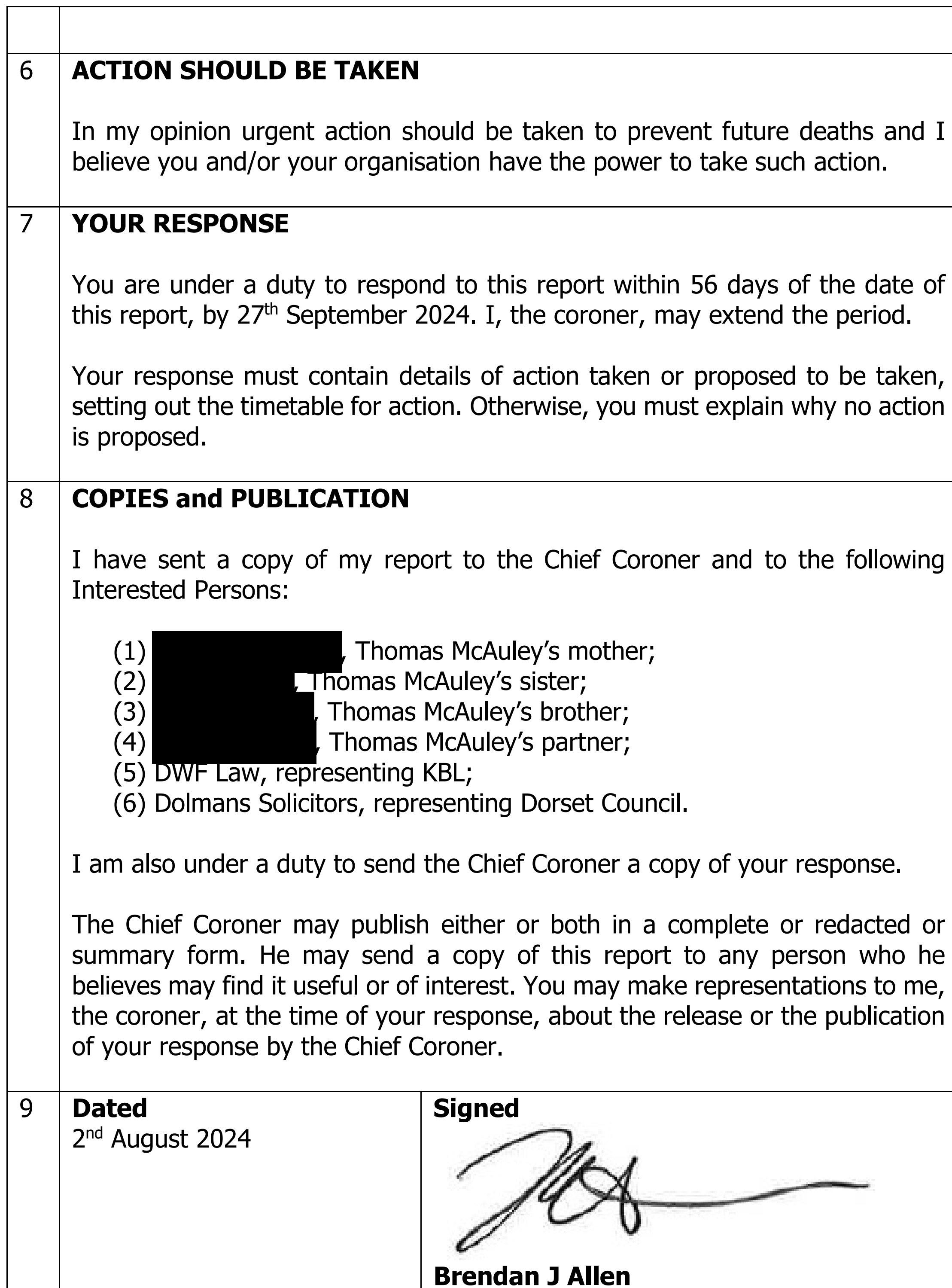
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Health and Safety Executive**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 13th July 2022, an investigation was commenced into the death of Thomas Joseph McAuley, born on the 1st April 1968. The investigation concluded at the end of the Inquest on the 19th July 2024. The Medical Cause of Death was: 1a Multiple Injuries 1b 1c 2 The conclusion of the Inquest recorded that Thomas Joseph McAuley died as a consequence of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Thomas Joseph McAuley was employed by Kiely Brothers Limited ("KBL") as part of a crew of men undertaking road resurfacing works. On 5th July 2022, Mr McAuley, together with a crew of 6 others, was undertaking resurfacing work

	in Redwood Drive, Ferndown. At approximately 11 am Mr McAuley placed himself within the area between the third and fourth axles of a four axle, 32 tonne grab lorry that was on site. This was likely so that he could urinate. The driver of the grab lorry was unaware of Mr McAuley's presence within this area and moved the grab lorry forward a short distance and at low speed, causing Mr McAuley catastrophic injuries that caused his death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. It is common practice for members of roadwork crews to use the space between the rear axles of LGVs to urinate, even when a welfare van has been provided on site. A witness who had worked for at least one company as part of a roadwork crew prior to joining KBL gave evidence that it was a practice that he was aware of "since starting on the roads". Although it would seem that KBL employees no longer engage in this practice, likely because of the tragic death of Mr McAuley, there was no evidence available at the Inquest to suggest his death had had an impact on the industry more widely. 2. I have concerns with regard to the following: i. If the practice of using the space between the rear axles of an LGV is ongoing, there remains a risk of future deaths, as any small movement of the vehicle can cause fatal injuries. I am not aware of any safety notice(s) being issued since Mr McAuley's death or any wider publicity that may have highlighted the risk. Ensuring that companies undertaking road resurfacing work or similar are made aware of the risk that this practice is ongoing will enable them to take measures to address this potential ongoing risk.



6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, by 27th September 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: (1) , Thomas McAuley's mother; (2) , Thomas McAuley's sister; (3) , Thomas McAuley's brother; (4) , Thomas McAuley's partner; (5) DWF Law, representing KBL; (6) Dolmans Solicitors, representing Dorset Council. 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	**Dated** 2nd August 2024	**Signed** **Brendan J Allen**