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:** **1 [redacted], Ward Bros (Malton) Ltd, Dormor Way, South Bank, Middlesbrough TS6 6XH**
1	**CORONER** I am Clare Bailey, Senior Coroner for the coroner area of Teesside and Hartlepool
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 16 January 2019 I commenced an investigation into the death of Gary Lee JAMES aged 30. The investigation concluded at the end of the inquest on 31 January 2025. The jury determined that, Gary Lee James was employed as a fork lift truck operator at Ward Bros (Malton) Ltd. He was working at South Bank Middlesbrough plant. On 19, 20 & 21 December 2018, Mr James was shown and engaged in the devanning of welded storage containers. On 19 & 20 December the first three frames were stood flat, stacked on top of each other. Later during 20 December, the first three frames were moved so that they were stood upright. On 20 & 21 December the remaining three frames were stored upright. The vertical frames were not secured. The storage container housing the six vertical frames was relocated on 21.12.2018. The container was moved again on 07.12.2019. The movement of the storage container caused the frames inside to fall. Gary checked upon the frames on 08.01.2019 and saw that the six frames were stood at a 45 degree angle. He entered the storage container with a colleague. They tried to move the six frames by hand, so the frames were stood up. Whilst moving the sixth frame the fifth frame started to fall towards them. This was followed by the other four frames. Gary was trapped by his neck by the frames. He was transported to James Cook University Hospital. He died at James Cook University Hospital on 11.01.2019 due to injuries sustained by being trapped in the falling frames.
4	**CIRCUMSTANCES OF THE DEATH** The jury came to narrative conlusion; Gary died at James Cook University Hospital from injuries sustained in being trapped by metal frames at Ward Bros on 08.01.2019. His death was contributed to by: 1) There was not appropriate risk assessment & safe working practices and procedures in place prior to the commencements of devanning the welded containers. 2) Ward Bros had not considered the potential hazards in removing, transporting and sorting the welded frames in advance of the first frames being dismantled on 19.12.2018. 3) The logistics of storing 20 horizontally stacked frames had not been fully considered and assessed. 4) Gary had not received adequate and appropriate training in the devanning role.

	5) There was not sufficient and appropriate supervision of Gary and his colleagues whilst the devanning of welded containers was undertaken. 6) No consideration was given to the vertical frames being secured in the container. 7) The 6 standing frames were not secured on 21.12.2018 and subsequently became loose before the container was checked on 08.01.2019. 8) Employees did express concerns to Ward Bros about safety of the devanning process and such concerns were not listen to and acted upon. 9) The general attitude in Ward Bros was one of getting a task completed in spite of health & safety concerns and risks. 10) Gary thought he was acting in line with earlier Ward Bros directions in trying to stand the frames on the morning of 08.01.2019. 11) On 08.01.2019 it was not safe for Gary and a colleague to move the 6 frames by themselves and in relative darkness. 12) The methods employed by Gary and a colleague to move and stand the frames on 08.01.2019 were not safe. 13) Gary and a colleague were not appropriately and adequately supervised on 08.01.2019.
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: (brief summary of matters of concern) 1. No risk assessment and subsequent safer working practice document in respect of new work undertaken. 2. Work was undertaken on a trial-and-error basis, exposing employees to hazards. 3. There was inadequate and inappropriate training for employees. 4. The use of unsafe and unsuitable equipment in new work undertaken. 5. Lack of suitable PPE worn by employees i.e. hard hats. 6. Employees working in inappropriate conditions (in the dark inside containers/alongside Forklift Truck inside containers) 7. There was a failure to acknowledge or act upon employee's health & safety concerns. 8. A general approach of having to "get on with a task" in spite of health and safety concerns and dangers to employees. 9. No first aid assistance was provided by a trained first aider before the arrival of the emergency services. 10. Failure to adequately supervise employees.
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 April 09, 2025. 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, MSC . 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:12.02.25** **HM Senior Coroner for Teesside & Hartlepool**