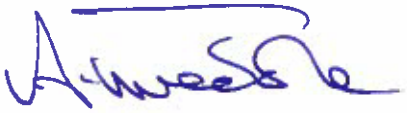
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Director, Beamish Museum, Beamish, Co Durham DH9 ORG** **2. [redacted] HSE, Alnwick House, Benton Park View, Newcastle upon Tyne NE98 1YX**
1	**CORONER** I am ANDREW TWEDDLE Senior Coroner, for the Coroner Area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 26th July 2012 I commenced an investigation into the death of Karl Doran aged 7 years. The investigation concluded at the end of the inquest on 2nd December 2013. The conclusion of the inquest was Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a seven year old boy, who together with his father, were volunteers at Beamish Museum in County Durham. [redacted] drove a steam roller around the Museum's roads and was accompanied by his son, who at various times on the day in question rode on the steam roller/at the back of the steam roller/standing on an "A" frame linking the steam roller to a trailer/sitting on said "A" frame. Both father and son had been engaged in similar activities at Beamish on a number of occasions in the past, though this was the first occasion when they had used this combination of steam roller and trailer. There was no clear witness evidence as to where Karl was immediately prior to him falling and almost immediately thereafter being crushed by the heavy steel wheeled trailer. Karl's death would have been almost instantaneous.
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) Beamish had not carried out a appropriate risk assessments to ensure the safety of volunteers such as Karl and his father when engaging in activities around the museum site. There was no direct or in-direct managerial supervision of these volunteers activities.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. Action should be taken by Beamish to carry out a full and detailed risk assessment of all aspects of the use of steam powered vehicles in the museum to ensure the safety of staff, volunteers and the public and to exercise proper managerial control over such people to ensure their safety. HSE gave evidence that there is little specific guidance on the issue, though comparable equivalent advice can be gleaned from the use of agricultural machinery, though the National Traction Engine Trust does give guidance and assistance to members and

	others with regard to the safe use of traction engines. HSE accepted in evidence that it has an educational role in health and safety matters and should disseminate the lessons learnt from this case to as wide a possible audience as is possible who might benefit from it, including, but not exclusively, the National Traction Engine Trust.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30th January 2014. 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] I have also sent it to the following who may find it useful or of interest [redacted] Darlington Safeguarding Board [redacted] County Durham Safeguarding Board 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	**5th December 2013**  **Andrew Tweddle LLB** **H M Senior Coroner** **County Durham and Darlington**