REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Managing Director** **FALCON CRANE HIRE LIMITED** **Shipdham** **Thetford** **IP25 7SD**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 4 February 2014 I commenced an investigation into the death of RICHARD ANTHONY TURNER. The investigation concluded at the end of the inquest on 18 November 2014. The conclusion of the inquest was medical cause of death: 1a) Multi organ failure b) Abdominal sepsis c) Trauma to the pelvis and abdomen due to Industrial accident and short form conclusion: Accidental Death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Turner was employed as a Slinger and on 10 January 2014 he was working with a co-employee, a Crane Driver. Both men were recognised by witnesses to be suitably qualified and experienced. Both men worked together on a daily basis in the same yard dealing with the same equipment, namely loading and unloading cranes. On 10 January 2014 Mr Turner attached the lifting equipment to the crane jib section and the Crane Operator raised the jib to move it. During the manoeuvre the section fell onto Mr Turner crushing him. He was taken to hospital where he underwent several procedures. Mr Turner died on 4 February 2014.
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) By working closely with the same person and dealing with the same type of work in the same place, employees can become complacent with regard to health and safety and the risks involved in their work (2) Lifting Plans were signed by employees dealing with conducting a lifting operation, planning and preparation, supervision requirements, and other safety procedures to be followed which were signed by Mr Turner on 29 November 2011.

	(3) There does not seen to be any standard procedure in place to remind employees of these Lifting Plans, risks involved, health and safety issues with regard to the work. (4) There was evidence of only one “Toolbox Talk” having taken place since the accident.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 23 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] Health & Safety Executive 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	**25 November 2014** **……..** **SIGNED BY CORONER**