REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Road Haulage Association** **Roadway House** **Bretton Way** **Bretton** **Peterborough PE3 8DD** **2. The Freight Transport Association Ltd** **Hermes House** **St John's Road** **Tunbridge Wells** **Kent TN4 9UZ** **3. [redacted] (UK Distributor of Le Gras Trailers)** **122 Glandon House** **Cheadle Hume** **Cheadle** **Cheshire SK8 7HD** **4. Steadplan Ltd (UK Distributors of Stas Trailers)** **Salthill Industrial Estate** **Lincoln Way** **Clitheroe BB7 1QL**
1	**CORONER** I am Julian Fox, assistant coroner for the coroner area of South Yorkshire (West)
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 8th July 2014 I commenced an investigation into the death of Paul Littlewood, aged 48. The investigation concluded at the end of the inquest on 11th May 2015. The conclusion of the inquest was that Mr Littlewood died of head injuries incurred when he fell from the gantry of a Le Gras trailer. The jury was unclear how he came to fall.
4	**CIRCUMSTANCES OF THE DEATH** Whilst unsheeting a walking floor trailer manufactured by LeGras, Mr Littlewood, who was described as a very safety conscious man, fell from the gantry at the front of the trailer, sustaining head injuries from which he sadly died the following day. Evidence was given that in all material respects, the design of LeGras and Stas gantries is identical.
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) The fixed barrier at the centre of the gantry was 1 metre in height, and there was no intermediate crossbar, leaving a gap of 1 metre, through which it would be quite easy to fall. (2) There was no toe-plate to delineate the edge of the platform (3) The gantry was accessible by means of a fixed ladder. At the top of the ladder, fall protection is provided by a single cable which is set at a height well below 1 metre. It provides a pivot for a fall, rather than fall prevention. (4) In my opinion, both the fixed barrier and the fall protection at the top of the access ladder should be set at a safer height. Reference to the Working at Height Regulations 2005 may well provide helpful guidance. (5) Consideration should be given to a self-closing mechanism for any barrier that is fitted at the top of the access ladder. (6) Consideration should also be given to the installation of a falls arrest system which can be attached at ground level. R Plevin and Sons Ltd have indicated that since Mr Littlewood's death, they have retro-fitted a system that they consider suitable at a cost in the region of £500.00 per trailer.
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 30th July 2015. 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] R Plevin and Sons Ltd The Health and Safety Executive (Sheffield Office – [redacted] I have also sent it to the Secretary of State for Transport who may find it useful or of interest. 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	**13th May 2015** **Julian Fox**