ANNEX A

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. Ministry of Defence** **2.** **3.**
1	**CORONER** I am Dr Elizabeth Earland, senior coroner for the coroner area of Exeter and Greater Devon.
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 1st May 2014 I commenced an investigation into the death of Cameron William LAING, aged 20. The investigation concluded at the end of the inquest on 8th July 2015. The conclusion of the inquest was a Narrative verdict – Private Cameron Laing of 7 Regiment Royal Logistic Corps was part of a unit which had taken a wrong turn when following an incorrect route card, arriving at Bracken Tor Youth Hostel instead of Okehampton Army Camp. At approximately 20.45hrs 29th April 2014 he was crushed between the back of a DROPS Lorry and the front of a 4 tonne, twin axle Kings Trailer. Death was virtually instantaneous. The effect of re-attachment of the air line while the emergency brake was on was not appreciated by those involved. The jack leg supporting the A Frame of the trailer and wooden chocks were not deployed. The trailer was on a 12° slope.
4	**CIRCUMSTANCES OF THE DEATH** Male was a member of 7 Regiment RLC (Royal Logistic Corps). On 29/04/14 male was on duty delivering storage containers to Okehampton camp. It appears that the 4 vehicle convoy he was in took a wrong turn down a track to Bracken Tor. It is believed that the location is not MOD property. He became involved in assisting his colleagues to remove by hand a large gun trailer (weighing 4 tonnes) from the rear of one of the military lorries (second in the convoy) to allow it to turn around. The trailer was first to be turned around manually by personnel then the military wagon which was transporting the containers was manually turned around.

	During the process of hitching the trailer back onto the lorry the deceased appears to have been bent down on one knee with his arm underneath the trailer / wagon trying to re-attach the trailer A frame hook. Another soldier was in charge of moving the trailer towards the wagon to enable re-attachment of the trailer by manual control using some kind of pneumonic device. Soldier shouted to make sure all soldiers were clear, the response was "yes" so the release button was pressed and the trailer moved very suddenly and relatively quickly (due to mass of trailer and also incline of the hill) and the trailer has then pinned the male's head and chest to the rear of the military lorry. Police have CCTV of the incident. Male was heard to shout out (probably in the moments prior to crushing) and seen to immediately go limp on impact with a change in the shape of his skull. The lorry was then moved very shortly after the incident and male's body fell to the ground and CPR was attempted. The ambulance was called at 20:48hrs and on arrival CPR was in progress, male had extensive facial, head and chest trauma. Airway was compromised by fractures of the jaw, eye sockets and skull with extensive bleeding. Male was intubated at the scene with full resuscitation (ALS). There was unequal chest rise; right sided of chest deformed. Male was asystolic throughout resuscitation. After 47 mins, male was declared dead at the scene at 21:49. Police; CID, SOCO and SCUI attended the scene to conduct an investigation. Health and Safety (HSE) have been advised PMH from military: wrist and hand sprain (26/01/2012), allergic reaction to insect bite (24/07/2012), smoker (20 per day), no known allergies, not on any medication
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. It was clear from the evidence, and reflected in the Juror' findings, that the Soldiers in Cameron's Packet were not aware that when the emergency brake locked on, upon depletion of air tanks on a kings Trailer, reconnection of the air (red line) would release the brakes once operating pressure was achieved. Thus would cause the trailer to move out of control if the hand brake was not applied. None of the witnesses who were trained to varying degrees understood this or the mechanism of brake action which was admittedly complicated. The Packet Commander was not fully trained in coupling and un-coupling procedures and relied on the Soldiers in her unit to advise her. This lack of understanding led to the accident that caused Cameron's death. 2. We received evidence from the Vehicle Examiner that an alternative method of extracting the trailer from the confined area at Bracken Tor Hostel would have been able to pull the trailer backwards via a DROPS vehicle, which had the necessary towing attachments, from behind or "nose manoeuvre" the trailer. Neither of these possibilities (which would have avoided manual handling and vulnerability to being trapped between the trailer and the DROPS) were taught to the Soldiers or recognised by them to be a solution to recovery of the trailer. 3. I am concerned that in WO1 Orpe's Table of Responses by the Ministry of Defence to the Land Accident Investigation Team report p8, paragraph 27, the

	Ministry of Defence Logistic training team take the view that such training of alternative manoeuvers cannot be delivered as they "do not appear in the Army Equipment Support Publication ". This does not appear to be a rational approach to the evident need for Soldiers to be given alternative methods of extracting themselves/vehicles from difficult situations, which in this case resulted in Cameron's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action and I therefore require a review of the Logistic Training Teams position on this point.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 4th September 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, the Next of Kin of the deceased and the Health and 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	**10th July 2015**