

IN THE SURREY CORONER'S COURT

**The Inquests Touching the Death of Ben Andrew Collins
A Regulation 28 Report – Action to Prevent Future Deaths**

	<p>THIS REPORT IS BEING SENT TO:</p> <ul style="list-style-type: none">• Digsafe Suction Excavations Ltd• Health and Safety Executive
1	<p>CORONER Simon Wickens HM Area Coroner for Surrey</p>
2	<p>CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.</p>
3	<p>INVESTIGATION and INQUEST The inquest into the death of Ben Andrew Collins was opened on the 4th August 2015 and was resumed on the 26th July 2016 before a jury. It was concluded on 1st August 2016.</p> <p>The cause of death was:</p> <ol style="list-style-type: none">1a. Positional Asphyxia2. Fractured Ribs and Femur <p>The conclusion of the jury was; Accidental Death</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 27th July 2015 Mr Collins was using a Suction Excavation Machine on behalf of his employer Digsafe Suction Excavations Ltd in order to excavate a trench beside the M3 Motorway. Whilst excavating, Mr Collins was seen on CCTV to enter the trench whilst the suction machine was directly above him, take off the machine's control panel from around his waist and drop it onto the ground beside the trench before bending down into the trench. On dropping the control panel the suction machine</p>

	<p>began to descend and trapped Mr Collins in the trench. The Court heard evidence that the control panel was faulty in that involuntary downward movement of the excavator could be engaged unintentionally due to wear and tear of the joystick.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest the evidence revealed that upon finding Mr Collins in the trench, those present had no knowledge of how to operate the Suction Excavator in order to release Mr Collins. Digsafe Excavations Ltd provided one person with knowledge of how to operate the excavator with an expectation that a second man would be provided by whosoever contracted with them. That person however would not know how to operate the Suction Excavator in an emergency or be fully trained in its use. Further there is no HSE guidance covering;</p> <ul style="list-style-type: none"> a) the use of a Suction Excavation machine, b) training for such use, c) the provision of a fully trained second man, d) the regularity of servicing of control panels. <p>MATTER OF CONCERN:</p> <p>Digsafe Suction Excavation Ltd give consideration to the provision of a second man by them at each excavation who is fully trained in the operation of the Suction Excavator and associated equipment such as an air-lance.</p> <p>The HSE give consideration to the provisions of guidance regarding training and the use of suction excavation equipment including a recommendation for the provision of a second man fully trained to use the Suction Excavator and associated equipment, regular servicing of remote controllers together with the proper documentation of such.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.</p> <p>Your response must contain details of action taken or proposed to be</p>

	taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: <ol style="list-style-type: none">1. Digsafe Suction Excavation Ltd.2. Health and Safety Executive3. [REDACTED]4. [REDACTED]5. Mway Communications Ltd6. The Chief Coroner
	Signed: <i>Simon Wickens</i> DATED this 10th August 2016