	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Head of Operations South West** **Health and Safety Executive** **2 Riverside** **Bristol** **BS1 6EW**
1	**CORONER** I am Lydia Brown, Assistant Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17/02/2016 I commenced an investigation into the death of David Ivor Alexander, 61 . The investigation concluded at the end of the inquest on 14 February 2017. The conclusion of the inquest was Cause of death - Chest Injuries Narrative conclusion – the Jury unanimously concluded that the death was accidental, with the gradient of the yard being a significant contributory factor.
4	**CIRCUMSTANCES OF THE DEATH** David Alexander was an experienced lorry driver and mechanic, delivering animal feed to a farm. Whilst David was engaged in transferring the feed from the HGV articulated lorry by the method of bulk blowing, the transfer pipes blocked and had to be manually emptied and the farmer assisted with this. Unloading continued, solely under the control of David. The hydraulic ram was employed to lift the trailer to almost full height, the bulk blowing recommenced, but then almost immediately the trailer tipped over with an almost full load of 25 tonnes of feed, and landed on top of David, killing him instantly. On close inspection it was ascertained that the lift had taken place while the vehicle was parked on a small gradient of between 2.9 and 3.6 degrees. It was also identified that the bracket holding the base of the hydraulic ram had stress fractures that were not visible from a normal manual inspection, but one side of the bracket failed, either causing or as a consequence of the overturn. Evidence was heard that without the gradient, this catastrophic failure was unlikely to have occurred.
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.

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	The **MATTERS OF CONCERN** are as follows. – (1) Evidence was taken during the inquest that overturns are not uncommon in this particular section of the industry, but are infrequently reported as there is no requirement to do so (2) The cause/s of overturn are not well understood or recognised as post event investigations are not carried out and there appears to be little knowledge or industry practise regarding regular inspections and/or replacement schedules in respect of the hydraulic ram brackets (3) There is little or no industry guidance available relating to this issue (4) It is not standard to fit new articulated lorries with inclinometers and they are not routinely, if ever, used on older vehicles notwithstanding that it is recognised that a very slight gradient of over 2 degrees can (at full extension of the hydraulic ram when fully loaded) cause overturn. This information does not appear to be widely recognised within the industry.

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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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 April 2017. 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:- The family of David Alexander NWF Agriculture Limited I have also sent it to Agricultural Industries Confederation and the Farm Safety Partnership 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	Dated 14 February 2017 Signature_____ for Exeter and Greater Devon

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