



H M Assistant Coroner for Gloucestershire
Caroline Saunders

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Tonic Construction Ltd2. Health and Safety executive [REDACTED]
1	<p>CORONER</p> <p>I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 7th June, the senior coroner commenced an investigation into the death of Shaun Carter. The investigation concluded at the end of the inquest on 19th July 2017. The conclusion of the inquest was a narrative conclusion. The medical cause of death was:</p> <p>1a) Blunt Head Trauma.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Shaun Carter was employed by Tonic Construction and on 31st May 2016 he was engaged in removing spoil to a spoil heap at a construction site in Cirencester. Evidence demonstrated that Shaun drove his dumper truck up the spoil heap, however at the top the truck went over the edge. Shaun jumped from the dumper truck but was struck by it during the fall. He suffered catastrophic injuries and was pronounced dead at the scene.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">1. At the inquest there was evidence that the risks associated with the use of dumper trucks was recognised and that risk assessments and method statements were written which reflected these risks. However the safety procedures were not followed, not seen by all relevant personnel (some of whom could not read) and the practice in this regard was not audited.2. At the inquest it was confirmed that there was no process in place to ensure that spoil heaps were managed safely, nor any guidelines issued by the HSE in this regard. This has been addressed by Tonic Construction in relation to the sites it manages, but there are still no industry standards relating to the management of spoil heaps.3. Dumper trucks are designed to ensure that drivers are protected, even if the dumper trucks topple over. However the inherent open nature of trucks can nonetheless make the driver feeling vulnerable and despite the instructions which require the driver to

	remain seated during an incident, statistics indicate (as in this case) that the natural reaction of drivers is to jump from the truck.
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6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p> <p><u>Tonic Construction Ltd</u></p> <p>In relation to point (1) above, I have heard of the changes that have been made in practice however I should like reassurance regarding the safety culture and the processes for auditing that practices are known by all and adhered to.</p> <p><u>Health and Safety Executive</u></p> <p>In relation to Point (2) above. At the inquest I heard evidence from [REDACTED] HSE investigator that there is scope for guidelines to be extended by the HSE and circulated throughout the industry which is dedicated to the construction, management and inspection of spoil heaps.</p> <p><u>Health and Safety Executive</u></p> <p>In relation to Point (3) above. I should like to be informed whether the HSE is issuing any guidelines to the industry to consider whether the design of dumper trucks should be explored, which takes account of the natural human response in an accident, to jump from a falling truck.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm on 25th October 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>(1) The family of Shaun Carter (2) [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 29th August 2017</p> <p>Signature <u>Caroline Saunders</u></p> <p>Caroline Saunders HM Assistant Coroner for Gloucestershire</p>