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:-** **Rose Builders and Contractors Ltd** **Riverside House, Riverside Avenue East** **Lawford, Manningtree** **Essex CO11 1US**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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 12 October 2016 I commenced an investigation into the death of David Scott Green. The investigation concluded at the end of the inquest on 13 March 2017. The conclusion of the inquest was:- ***David Scott Green died as a result of an accident***
4	**CIRCUMSTANCES OF THE DEATH** David Green, who was 32 years old at the time of his death was driving a dumper truck at Coxs Hill Lawford, Manningtree, Essex on the 3 October 2016 over a mound of earth. The ground gave way and the vehicle toppled forward over the edge. His seat belt was not in use and he ended up underneath the vehicle.
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. – • There did not appear to be a safe system of work in operation on the site. • There seemed to be a widespread practice of employees not wearing the seat belts provided with the vehicles. • There seemed to be an inadequate system of checking whether or not employees were wearing seatbelts in the course of their work. Cont…..

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 working days of the date of this report, namely by 19th April 2018. 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 – Hutcheon Law , solicitors for the family 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	**[DATE] 01 February 2018** **Caroline Beasley-Murray**