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. **Treanor Pujol Limited, Pontefract Road, Leeds, LS10 1RU**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the coroner area of West Yorkshire (Eastern)
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 6th June 2014 an Investigation was commenced into the death of Matthew Luke Fulleylove, aged 30. The Investigation concluded at the end of the Inquest on 26th April 2018. The conclusion of the Inquest was that Mr Fulleylove died from a head injury (1a). A Narrative Conclusion was returned by the Jury.
4	**CIRCUMSTANCES OF THE DEATH** On 5th June 2014 Mr Fulleylove sustained a fatal injury when his head became trapped as two heavy industrial machines passed on adjacent rail tracks during the production of large concrete beams at the premises of Treanor Pujol Ltd, Pontefract Road, Leeds.
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) A Witness at the Inquest expressed concern about the safety of operatives who have only a restricted space in which to work in the vicinity of metal support legs at the side of track 12 in the factory. As heavy railed machines with rotating industrial saws are operating in close proximity concerns were raised as to the risk of fatal injuries being sustained due to the limited space available. (2) A Witness told the Inquest that heavy industrial machines of the type involved in this fatality do still pass each other on tracks 11 and 12 despite criticisms voiced by an Expert Engineer in relation to the small gap between them coupled with the fact that some of the remedial safety measures advocated by the Expert Engineer have not been implemented. In fairness, it recognised that a Director of Treanor Pujol Limited did attempt to explain that the incidence of 'machinery passes' is now much reduced and some protective measures have been implemented, together with greater levels of suspension and training. Nonetheless,

	concern remains that any relaxation in the stringent system of work advocated by the Expert Engineer may give rise to a repetition of the circumstances which brought about the fatality on 05/06/2014.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 25th June 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. 1. [redacted] (Mother) 2. [redacted] (Partner) 3. [redacted] (Health and Safety Executive) I have also sent it to [redacted] 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	**30th April 2018** **Mr Kevin McLoughlin** **Senior Coroner** **West Yorkshire (Eastern)**