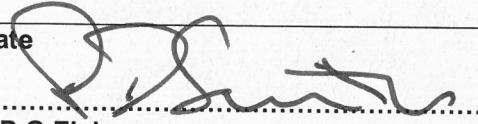




**Stuart P G Fisher  
HM Senior Coroner  
County of Lincolnshire**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1. Health and Safety Executive, Engagement and Policy Directorate</b></p>
1.	<p><b>CORONER</b></p> <p>I am Stuart P G Fisher, Senior Coroner, for the coroner area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.</p>
2.	<p><b>CORONER'S LEGAL POWERS</b></p> <p>-</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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made">http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made</a></p>
3.	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 9 March 2018 I commenced an investigation into the death of PETER JOHN LETT, aged 53 years. The investigation concluded at the end of the inquest on 28 August 2018. The conclusion of the inquest was that PETER JOHN LETT died as a result of Accidental Death, the medical cause of death being:</p> <p>1a. Multiple Injuries</p>
4.	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 9 March 2018 Mr Lett attended Heckington Windmill in his capacity as a volunteer. His clothing became entangled on the crankshaft of a Ruston Hornsby engine in an engine shed situated adjacent to the windmill. He sustained fatal injuries.</p>
5.	<p><b>CORONER'S CONCERNS</b></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 <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>During the Inquest it became clear that there was a dearth of HSE Guidance in respect of historic and heritage equipment, much of which is unguarded and potentially extremely dangerous. Clear guidance needs to be produced by the HSE, failing which it is highly probable that further deaths will occur.</p>
6.	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.</p>

7.	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 9 January 2019. 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><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>(a) [REDACTED]</p> <p>(b) Heckington Windmill Trust</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>
RP	<p>Date </p> <p>.....</p> <p><b>S P G Fisher</b> <b>Senior Coroner</b></p>