

## H M Senior Coroner for Gloucestershire Ms Katy Skerrett

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** THIS REPORT IS BEING SENT TO (i) Senior Traffic Commissioner, The Driver Vehicle Standards Agency, Officer of the Traffic Commissioner, Eastbrook, Shaftsbury Road, Cambridge, (ii) Mr R Burnett, Chief Executive Officer of The Road Haulage Association, Roadway House, Bretton Way, Bretton, Peterborough, PE3 8DD. CORONER I am Katy Skerrett, Senior Coroner for Gloucestershire. 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 the 26<sup>th</sup> April 2018 I opened an inquest into the death of Christopher George Barnes. The investigation concluded at the end of the Jury inquest on the 9<sup>th</sup> May 2019. The conclusion of the Jury was a short form conclusion of Accidental Death. The medical cause of death was 1A traumatic intra-cranial haemorrhage, 1B Fall from the load on the bed of the lorry. 4 CIRCUMSTANCES OF THE DEATH Mr Barnes was a 69 year old lorry driver employed by a haulage contractor. On the 23<sup>rd</sup> April 2018 he was delivering doors in his curtained side HGV to a company in Fairford. Employees of this company unloaded the HGV. During this process Mr Barnes climbed up onto the bed of the lorry. He then climbed up onto the palletised load. Whilst attempting to untangle the straps which were used to secure the load he took a step back and fell from the lorry impacting with the concrete floor below. He fell approximately 2.3 metres. He was initially unconscious and was transferred by air ambulance to the regional specialist unit. CT investigations demonstrated that he had sustained significant head injuries. He underwent operative intervention. Post operatively his condition steadily deteriorated. He passed away as a result of his injuries at 22.05 hours on the 24<sup>th</sup> April 2018. 5 **CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. Whilst the haulage company and the destination company involved in this incident have addressed all the health and safety concerns surrounding this area of practice, 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. -Whether consignees and consigners and their employees have sufficient understanding of the

and whether they ensure an appropriate level of safety and have in place sufficient control

hazards and risks associated with working at height on a vehicle or vehicle trailer,

measures to satisfy their legal obligations.

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 4pm 15 <sup>th</sup> July 2019. 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 I am also under a duty to send the Chief Coroner a copy of your response.  (1)
	(2) Devereux Developments Ltd, BLM - Law, FAO Ms Udale, Princes Exchange, 2 Princes Square, Leeds, LS1 4HY
	(3) Cotswold Doors Ltd DAC Beachcroft, Portwall Place, Portwall Lane, Bristol BS1 9HS.
	(4) HM Inspector of Health and Safety, Field Operations Division, Health and Safety Executive, 19 Ridgeway, Quinton Business Park, Birmingham B32 1AL
	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 20 <sup>th</sup> May 2019 Signature
	Ms K Skerrett
	Senior Coroner for Gloucestershire

4 M Coroner