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:** - **W E Rawson Ltd, Castle Bank Mills, Portobello Road, Wakefield. FAO The Managing Director**
1	**CORONER** I am Kevin McLoughlin, assistant 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 3 April 2014 I commenced an investigation into the death of Paul David Whitehead, Age 49. The investigation concluded at the end of the Inquest on 11 December 2015. The conclusion of the inquest was a Narrative Conclusion that Paul David Whitehead sustained serious injuries on Friday 28 February 2014 when working on a Desco packing machine in the course of his employment at W E Rawson Ltd, Castle Bank Mills, Portobello Road, Wakefield and subsequently died on Sunday 2 March 2014 at Leeds General Infirmary as a result of the multiple injuries sustained.
4	**CIRCUMSTANCES OF THE DEATH** Paul David Whitehead was a Charge Hand operating a Desco packing machine in the Bottom Mill in the course of his employment with W E Rawson Ltd on a night shift commencing around 6pm on Friday 28 February 2014. He was discovered trapped between the lower and upper moving conveyors of the machine having sustained severe crush injuries, from which he subsequently died.
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) When Mr Whitehead was released from the machine and fell on to the floor, a witness said that there was no one in the vicinity able to give First Aid to the casualty. (2) The designated First Aider from the Security Office, when informed of the incident rang the Health and Safety Manager before calling for an Ambulance. The statement giving this evidence was challenged, however, by the evidence taken at the Inquest from the Health and Safety Manager. (3) The First Aider who attended the casualty was herself in shock and unable to carry out mouth to mouth resuscitation.

	(4) The Paramedic who initially attended in response to the 999 call said in a statement that on arriving at the large site of W E Rawson Ltd the Ambulance stopped in a small car park but could not see anyone around and had to drive back on to the main road before eventually finding someone stood by a fire exit door. The Paramedic's statement said that from arriving at the site to arriving with the patient took approximately five minutes. These factors in combination suggest that the emergency response procedures at W E Rawson Ltd were not sufficiently efficient or effective. Whilst it is unlikely that these factors contributed to Mr Whitehead's eventual death, they do give rise to the concern that if another emergency were to arise involving a time critical situation, an avoidable death might occur. Evidence was taken at the Inquest to the effect that the Disaster Recovery Plan at W E Rawson Ltd was reviewed after Mr Whitehead's death but the conclusion reached that no significant changes were required. I consider that a further review of the standard of First Aid provision is merited along with the actions to be taken in the immediate aftermath of an unexpected occurrence to ensure that the Emergency Services are contacted immediately and steps taken to expedite their arrival with any casualty.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe W E Rawson Ltd 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 Monday 8 February. 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 Person: the family of Paul David Whitehead, [redacted] I am also under a duty to send the a copy of your response to the Chief Coroner. 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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14 December 2015** **Kevin McLoughlin, Assistant Coroner**