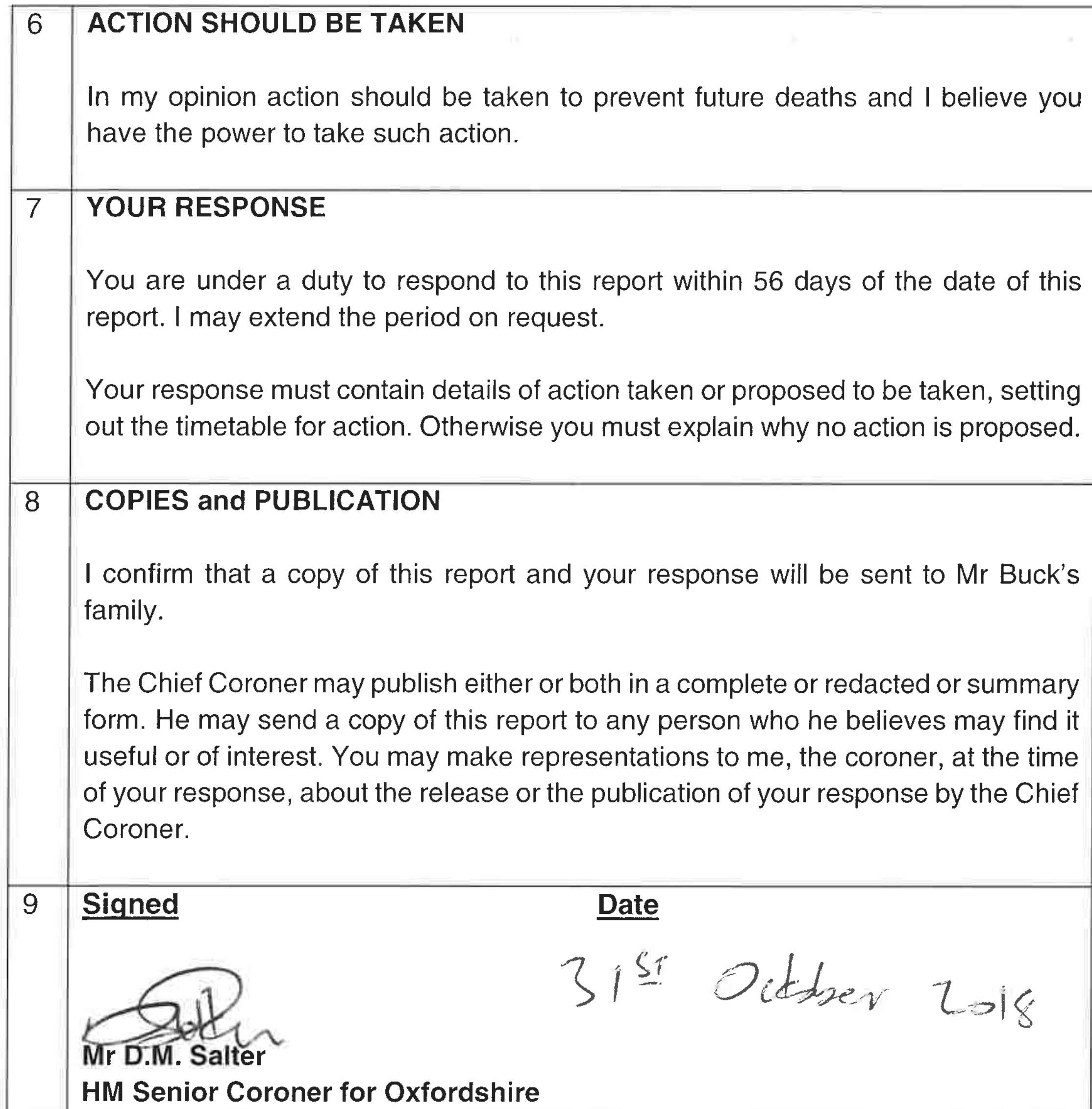
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chair, Waste Industry Safety & Health Forum**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION AND INQUEST** On 3, 4 and 5 October 2018 I concluded the inquest into the tragic death of Stephen Buck who was killed in Thame on 18 April 2017. A number of witnesses provided oral evidence including co-workers and managers. Given that this was a fatality in the work place, the case was heard before a Jury who returned a Conclusion of 'Accident' and made a finding that '*At approximately 10.30am on 18 April 2017, Stephen Buck was working at the Bloor Homes Site, Oxford Road, Thame. He was stood with his back to a reversing vehicle filling in tickets. The vehicle struck him and pulled him underneath the wheels. Resulting in his death.*'
4	**CIRCUMSTANCES OF THE DEATH** Stephen Buck was 58 years old when he died. His home address was near Neath in Wales but he had previously lived and worked in Oxfordshire and had been working for several months on this particular site at Thame. It was a Bloor Homes site for new housing but Mr Buck worked for ECL Ltd who were the sub-contractors undertaking the ground works. Stephen was a ground worker and he had worked in the construction industry for many years. The driver of the lorry which reversed over him was employed by a different company called David Einig Ltd, a construction haulage company. At the time, Bloor Homes were the principal contractor but the incident occurred on an area where ground works were being carried out by ECL and therefore there was a degree of segregation with no works being carried out in the vicinity by Bloor. In the months leading up to this incident there had been about 3 operations to remove spoil from the site as part of the ground works. The incident occurred near the end of the third 'muck away' operation at a time when the number of trucks on turnaround had reduced from about 20 to only 2. There was evidential uncertainty about whether Mr Buck was working as a banksman/traffic marshal and precisely what his role was and whether he should have been present at the location of the incident. It was established that during this third muck away operation he had previously been given the task of issuing tickets

	to the David Einig Ltd drivers when they collected loads from the spoil heap, having been loaded by a machine. On the morning of the incident, he was not present when the trucks collected loads on some occasions but he was on others and issued tickets to the drivers on occasions when he was present. There is CCTV footage from a rear camera on the truck of the tragic accident. It appears that Mr Buck walked onto the earth track whilst the truck was reversing and he stood stationary for a period of time but with his back to the reversing truck. It appeared he was writing out tickets. It appears he did not see or hear the truck (despite a reversing alarm) prior to the impact. I have only provided you with a brief overview. I attach however a copy of a brief Police Report dated 2 August 2018, a Collision Investigators Report with photographs and a Report from the HSE dated 29 August 2018.
5	**CORONER'S CONCERNS** **During the course of the Inquest the evidence revealed matters giving rise to concerns. 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 make this report to you.** The **MATTER OF CONCERN** is in relation to the following: It is a relatively narrow issue but one that is likely to be relevant to many construction and waste industry sites in the country. There are issues about the use of banksmen/traffic marshals when trucks and machines are reversing and I realise that this is of course an activity involving a recognised risk. The narrower issue I wish to raise is in relation to spoil removal/muck away operations where there are potentially a large number of trucks attending a site and, in many instances, there is likely to be a requirement for the trucks to reverse thereby increasing the risk to others. I heard evidence that it is common practice in the industry for a ground worker or other operative to be given the task of issuing tickets to the truck drivers. I understand there are at least two purposes. Firstly, so that there is a record of the number of loads for invoicing purposes. Secondly, because the spoil is controlled waste and there is apparently a need for such a ticket. The result though is that an operative is often required to be in close proximity to the trucks. Clearly, it would be preferable if this was not the case. The issue of concern therefore relates to the apparently common practice for an operative to work in close proximity to trucks to issue the ticket. One might have thought that a different system involving technology could remove the need for this to occur. It would be helpful if you could give consideration to this issue.



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. I may extend the period on request. 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 confirm that a copy of this report and your response will be sent to Mr Buck's family. 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	**Signed** **Date** 31st October 2018 **Mr D.M. Salter** **HM Senior Coroner for Oxfordshire**