HM CORONER
Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Transport 2. Health and Safety Executive
1.	**CORONER** I am Paul Duncan Smith, Area Coroner, for the Coroner area of Lincolnshire, 4 Lindum Road, Lincoln, LN2 1NN
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3.	**INVESTIGATION and INQUEST** On 19 November 2018 I commenced an investigation into the death of Ashley Mark Holden, aged 27. The investigation concluded at the end of the inquest on 11 December 2019. The conclusion of the inquest was that Mr Holden died as a result of an accident, the medical cause of death being: 1a. Head Injury
4.	**CIRCUMSTANCES OF THE DEATH** 1. On 10 November 2018 Ashley Holden was employed as an HGV driver. He was instructed by his employer to visit Staples Farm, Main Road, Stickney. Boston to collect a quantity of straw bales. 2. Although his employment had not commenced until 7 November 2018 he had visited that farm on previous occasions and had collected a similar load of bales without incident. 3. On 10 November, as previously, the trailer was loaded for him by farm operatives and the bales were loaded in accordance with the normal pattern. 4. The trailer had an extendable bar fitted to the rear which lengthened the trailer bed by approximately two feet. After the trailer had been fully loaded, Mr Holden noted that the bales, as loaded, were overhanging the trailer bed. He requested that a number of bales be removed from the rearmost section of the trailer as he wished to check that the bar was fully extended. 5. The farm operative removed a total of 9 bales from the very rear of the trailer, following which Mr Holden and the operative confirmed that the bar was fully extended. It was pulled out by an additional couple of inches only. 6. As that occurred, two of the remaining bales, being unstable, fell from the trailer, one of them striking Mr Holden and forcing his head onto the extended trailer bar where he sustained fatal injury.
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. – I received evidence that; 1. Fatalities from falling bales are an acknowledged risk within agriculture with a number of fatalities annually. 2. There are two specific guidance documents available to the public which are relevant to this issue; • Department of Transport Code of Practice, "Safety Loads on Vehicles" (2002) • Health and Safety Executive (HSE), "Safe Working With Bales in Agriculture" (2012) 3. The two pieces of guidance are not consistent in the approaches that they suggest and indeed the later guidance does not reference the earlier guidance. 4. There is no definitive guidance provided to the industry in relation to the stacking or unstacking of bales, or in relation to the loading and strapping of loaded trailers in a manner which takes account of the different sizes and composition of bales, and/or different trailer sizes and configurations. 5. The absence of specific guidance on this issue creates a risk of the development of unapproved and potentially unsafe individual practices, with the consequential risk of future deaths. 6. The provision of definitive guidance would be welcomed by those working within agriculture.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 10 July 2020. I, the Area 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 [redacted] Thorley Brothers Ltd Health and Safety Executive 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.
	Dated this 17th day of April 2020 ..... **Paul D Smith** **Area Coroner** **Lincolnshire**