REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **The British Standards Institute** **389 Chiswick High Road** **London** **W4 4AL** **The Container Handling Equipment Manufacturers Association** **Three Tree Barn** **Mill House Lane** **Croft** **Warrington** **WA3 7HA** **Dennis Eagle Ltd** **Heathcote Way, Heathcote Ind. Est.** **Warwick** **CV34 6TE** **Biffa Waste Services Ltd** **Coronation Road** **Cressex** **High Wycombe** **Buckinghamshire** **HP12 3TZ.**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 22nd January 2020 I commenced an investigation into the tragic death of Corrie MCKEAGUE The investigation concluded at the end of the inquest on 22nd March 2022. The jury conclusion of the inquest was that:- **Corrie McKeague died on the 24th September 2016 at approximately 04:20am in Bury St Edmunds as a result of compression asphyxia in association with multiple injuries, whilst in the back of a refuse lorry.** **Corrie's death was contributed to by:** **Impaired judgement due to alcohol consumption.** **Climbing into a 1100L commercial waste bin.** **Ineffective bin locks.** **Ineffective search of the bin.**

	Any driver not having the means to search the bin thoroughly or safely. **Poor visibility through the Perspex viewing window on the lorry** The medical cause of death was confirmed as: **1a Compression asphyxia in association with multiple injuries**
4	CIRCUMSTANCES OF THE DEATH **Corrie McKeague had been serving in the RAF for three years, and at the time of his disappearance on the 24th September 2016, was based at RAF Honington, in Suffolk.** **On the evening of Friday 23rd September 2016, Corrie drove his car into Bury St Edmunds where he subsequently met up with some of his RAF colleagues to go drinking and socialising. They ended up in the Flex nightclub in Bury St Edmunds.** **Corrie consumed a significant quantity of alcohol during the evening, although he remained both happy and friendly during the course of the night. However, due to his intoxication Corrie was ultimately asked to leave the nightclub.** **Corrie was seen on a number of occasions on CCTV cameras as he made his way through Bury St Edmunds.** **At 03.25 hrs on the 24th September 2016, CCTV showed Corrie entering a "horseshoe" shaped area in Brentgovel Street, behind a chemists and bakers.** **In that area were a number of commercial size (1100 litre) waste bins.** **At 04.19 hrs a Biffa Dennis-Eagle dust cart arrived at the horseshoe area and collected a bin from the rear of a Greggs bakers.** **The bin weight recorded by the lifting mechanism on the dust cart was 116kgs, which was significantly heavier than usual.** **Corrie was reported missing when he failed to report to work on the 26th September 2016.** **Subsequent analysis of the CCTV footage, failed to identify Corrie again after 03.25 and confirmed he did not leave the horseshoe area on foot.** **An extensive investigation and search operation failed to find Corrie, leading to the hypothesis that Corrie had been in the bin, and his body had been lost in a landfill site.** **Despite extensive searches Corrie was never found.** **At the request of Corrie's family, the Senior Coroner for Suffolk made an application to the Chief Coroner for England and Wales to hold an inquest into Corrie's death, in the absence of his body being found.** **The Chief Coroner for England and Wales subsequently directed that this inquest should be heard on the basis that, on a balance of probabilities, Corrie did come by his death on or about the 24th September 2016 in the vicinity of Bury St Edmunds.**

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – **In the conclusion returned by the jury, they identified 6 issues, which directly contributed to Corrie's death. This PFD Reports relates to 4 of those issues.** **1. Ineffective bin locks.** **The court heard that bin locks were designed to keep waste within the bin, keep inclement weather out, but were not designed to keep individuals out. The locks were described as not robust, and a determined or strong individual would get in. Due to their design the locks were also frequently broken.** **Stronger locks (such as snap locks) had been considered, but due to the risk of entombing (an individual inadvertently becoming locked inside a bin), stronger locks had been discounted. However, the court heard there are currently no stronger bin locks available which would allow an individual to open them from the inside should they become entombed in a bin.** **There were 740 reported incidents of people in bins over a 6-year period (i.e. 10 per week), which are likely to be reduced if stronger locks are fitted.** **2. Ineffective search of the bin.** **Despite the lifting mechanism recording the weight of each bin every time it is lifted, there is no automated/digital system to recognise when a bin is significantly heavier than it usually is.** **In this case the usual weight in the bin (based on an average of 13 previous collections) was approximately 15kgs. The bin weight recorded by the lifting mechanism on the dust cart was 116kgs. Such a significant difference in weight of a particular bin, is something that should be recognisable and should warrant a further check being completed.** **3. Any driver not having the means to search the bin thoroughly or safely.** **The court heard that drivers are now told to use a 'push stick' to allow a more thorough search of the contents of a bin. This instruction was not in place at the time of this incident.** **However, it was not clear from the evidence if the push stick is an identifiable piece of equipment on every vehicle, or if it is deemed as a piece of safety equipment, and therefore included in the daily safety checks of the vehicle.** **4. Poor visibility through the Perspex viewing window on the lorry** **In relation to the poor visibility through the Perspex viewing aperture/window on the lorry two factors were identified:** **Firstly, it is physically impossible to undertake a check of the hopper mechanism on the Biffa lorry as the viewing aperture window is too high for this to be achieved by an average height driver.**

	Secondly, on the six-year-old vehicle in question the Perspex had become opaque. **A Detective Constable who had watched the lifting process to provide evidence of its operation for the court, described the driver as standing on tiptoes to try a check the vehicle hopper, whilst peering around the wing of the lifting mechanism. When asked specifically about the viewing window the officer said it was too high to see through and opaque. The officer told the court the viewing aperture was 'totally useless' as a means of checking what was being loaded into the hopper.** **Whilst viewing the hopper is impossible on the current vehicle, it renders the instruction for drivers to view the hopper prior to compaction (contained in the Biffa Operating Instructions for Trade Waste Vehicles) impossible to achieve.** **In addition, the automatic nature of the compaction process, also makes adherence to the Operating Instructions impossible on some vehicles, as compaction starts immediately the bin is tipped.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th May 2022 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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; - 1. Corrie's family. 2. Suffolk Constabulary 3. Ministry of Defence 4. The vehicle driver I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**1st April 2022** **Nigel Parsley**