REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Wayne Clarey Roofing & Cladding Ltd** **2. Health & Safety Executive**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner, for the coroner area of The Black Country Jurisdiction
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 17/7/20 I commenced an investigation into the death of Adam Joseph Brunskill aged 22. The investigation concluded at the end of the inquest on 28/7/20. The inquest was held with a Jury and their conclusion was Accidental Death. The Jury made the following findings of fact; On 14/7/20 Adam Brunskill was working on the roof of a large warehouse. It was his second day of employment. Adam had received no accredited training prior to beginning work. The roof contained large sections of wired or Georgian glass. The glass sections were fragile and not safe to walk on. There were no safety barriers on the roof to identify the glass rooflights or to prevent a fall through the rooflights. There were no designated walkways. There was no safety netting inside the warehouse to mitigate a fall. Adam fell through one of the glass rooflights approximately 8 metres to the concrete floor below. The exact circumstances of the fall are unclear. He sustained a devastating brain injury and died the following day 15/7/20 in the Queen Elizabeth Hospital, Birmingham.
4	**CIRCUMSTANCES OF THE DEATH** The inquest heard evidence that Adam Brunksill was employed as a roofer by Wayne Clarey Roofing and Cladding on or around 11/12th July 2020. He was employed by [redacted] to work on a job involving the over cladding of a large industrial warehouse roof in Walsall. Adam had no prior experience working on a roof. He did not have his CSCS card (construction skills certification scheme) and he had not completed a mandatory one-day Health & Safety course. Adam was not shown the risk assessment or method statement for the job drawn up by the Principal Contractor. The roof area he was employed to work on was made up of 20% glass roof lights and was a fragile surface. The Jury found there were no safety barriers on the roof to identify the glass

	rooflights or to prevent a fall through the rooflights. The Jury found there were no designated walkways. The Jury found there was no safety netting inside the warehouse to mitigate a fall. On the morning of 14/7/20 Adam was allocated the job of laying down bars on the roof of the building in preparation for over cladding. Around 9 am Adam was discovered to be absent from the roof. A broken glass rooflight was identified. The evidence was that Adam had fallen through one of the glass rooflights approximately 8 metres to the concrete floor below. The exact circumstances of the fall are unclear. He sustained a devastating brain injury and died the following day 15/7/20 in the Queen Elizabeth Hospital, Birmingham. The Health & Safety Executive had conducted an investigation and the inquest was aware that no decision had been made at the time of inquest by the Health & Safety Executive about prosecution of either Wayne Clarey Roofing and Cladding had been made in relation to any criminal offences.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to 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** are as follows. – (**1) The Coroner heard at inquest that Adam had been employed by Wayne Clarey Roofing and Cladding to work on a roof with no prior experience of working on a roof and no CSCS card nor had he completed a mandatory one-day Health & Safety course;** **(2) On day 13/7/20 and 14/7/20 there was no evidence of a designated supervisor responsible for Adam on site and/or responsible for Adam's practical on the job training;** **(3) The Coroner did hear in evidence that one of the Principal Contractors who provided regular work to Wayne Clarey Roofing and Cladding would undertake to train any future unqualified employees of Wayne Clarey and provide access to an accredited training qualification and training matrix. The Coroner also heard that Mr Clarey had legal responsibilities under the Health & Safety at Work Act and the Construction (Design and Management) Regulations 2015. However, there was no evidence of any clear designated structured training programme in place by Wayne Clarey Roofing and Cladding for new and/or unqualified employees;** **(4) The Coroner did hear in evidence that one of the Principal Contractors who provided regular work to Wayne Clarey Roofing and Cladding would undertake to train any future unqualified employees of Wayne Clarey and provide access to an accredited training qualification and training matrix. The Coroner also heard that Mr Clarey had legal responsibilities under the Health & Safety at Work Act and the Construction (Design and Management) Regulations 2015. However, there was no evidence of any clearly identifiable supervisor and/or supervisory arrangements in place by Wayne Clarey Roofing and Cladding for new and/or unqualified employees;**

	(5) The Coroner did hear in evidence that one of the Principal Contractors who provided regular work to Wayne Clarey Roofing and Cladding would undertake to train any future unqualified employees of Wayne Clarey and provide access to an accredited training qualification and training matrix. The Coroner also heard that Mr Clarey had legal responsibilities under the Health & Safety at Work Act and the Construction (Design and Management) Regulations 2015. However, there was no evidence of any appraisal system in place by Wayne Clarey Roofing and Cladding.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 24/09/21. 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 [redacted]. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**3/8/21** **Mrs Joanne M. Lees Area Coroner**