THE CORONER'S OFFICE WOODVALE, LEWES ROAD BRIGHTON BN2 3QB

Assistant Coroners CATHARINE PALMER LL.B (HONS) GILVA D.J.TISSHAW, BA(LAW)HONS Telephone: Brighton (01273) 292046 Fax: Brighton (01273) 292047

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used after an inquest.

| | THE DEPOST IS DEING SENT TO |
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| | THIS REPORT IS BEING SENT TO: |
| | Chairman of the Board of Governors, Blatchington Mill School, Hove Head Teacher, Blatchington Mill School, Hove Business Manager, Blatchington Mill School, Hove Mr Geoff Raw, Chief Executive, Brighton and Hove City Council Senior Lawyer, Brighton and Hove City Council Head of Health and Safety, Brighton and Hove City Council Lead Consultant – Health, Safety & Wellbeing Team, Human Resources & Organisation Development, Brighton and Hove City Council |
| 1 | CORONER |
| · | I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove |
| 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 23 rd August 2018 I commenced an investigation into the death of David Alexander MOBSBY. The investigation concluded at the end of the inquest on 25 th , 26 th ,27 th ,28 th February and the 1 st and 4 th March 2019. The conclusion of the inquest was a NARRATIVE CONCLUSION . |
| 4 | CIRCUMSTANCES OF THE DEATH See Record of Inquest |

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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) Brighton and Hove City Council were "advising" Blatchington Mill School (BMS) on health and safety.
 - They were apparently using a template which made no mention of work at height when considering the health and safety of the facilities (caretaking/cleaning) department at BMS.
 - This is dangerous and may have led to the fact that neither of their audits of 2014 or 2018 made any mention of the risks associated with and training requirements regarding working at height.
- (2) Although Mr MOBSBY was employed either by Brighton and Hove City Council or BMS or a combination of the two, he was not monitored or instructed in his work.
 - He was allowed to choose how, when and where he worked. Even though anyone who knew his job description or knew Mr MOBSBY was aware that he was using ladders and step ladders he was untrained with regard to working at height.
 - On the 3rd August 2018 he was unchallenged when he announced his work programme for the day.
 - His line manager's did not instruct him with regard to the jobs he did, even though those jobs were considered to be unnecessary by the managers.
 - No methodology was explored when he announced his job for the day, there was no discussion about the equipment that he was going to use
 - There was no risk assessment undertaken in respect of any of the jobs that he did.
 - He was allowed to work alone and unsupervised. He lay alone and unconscious for 9-10 minutes before he was spotted. It was over 20 minutes before CPR was started. There was no first aider or designated person on the school site that day.
 - His working environment on the 3rd August 2018 meant that he was working with ambient temperatures of around 26 degrees centigrade.
 - He was not wearing a hat and he worked in the heat initially and then
 in direct sunlight latterly, from 0848 hrs until his fall at 1255 hrs having
 taken one forty minute break at 1100 hrs.

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| | It seems clear that working at BMS formed a huge part of Mr MOBSBY's life. He had been there for many years and was probably set in his ways and not amenable to being managed. Those managing him were all relatively new to their managerial posts and yet none of them had received any management training. It was clear they had no idea how to deal with him. They were not assisted by the fact that it was supposed to be the case that every employee was appraised annually. There was no evidence at all to suggest that Mr MOBSBY had ever been appraised. |
|---|---|
| | I am concerned that this situation which was demonstrated to be in existence at BMS could well be replicated, not only throughout Brighton and Hove, but throughout England and Wales and this is the reason why this Report has been sent to the Department of Education and I think the matters raised in it should have wider discussion throughout the Country. |
| | ACTION SHOULD BE TAKEN |
| | In my opinion action should be taken to prevent future deaths and I believe you AND your organisation 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 31 st May 2019. 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 |
| | 1. |

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| | 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. |
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| 9 | Date: 11 th March 2019 SIGNED BY: Harrillon Seeley Senior Coroner Brighton and Hove |