REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO:	
	1. Chief Executive, The Health and Safety Executive	
1	CORONER I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset	
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 the 5 th February 2021, an investigation was commenced into the death of Jamie Paul Woods, born on the 12 th August 1980.	
	The investigation concluded at the end of the Inquest on the 7 th December 2022.	
	The Medical Cause of Death was:	
	1a Multiple Injuries	
	The conclusion of the Inquest recorded that Jamie Paul Woods died as a consequence of an accident.	
4	CIRCUMSTANCES OF THE DEATH Jamie Paul Woods was a farm worker at Hawkins Farm in Dorset. Hawkins Farm is a family-owned dairy farm. As part of the fabric of some of the buildings on the farm, pre-cast concrete panels were used extensively, predominately as external walls for barns or similar. Typically, the concrete panels, which weigh approximately 800kg, are placed between vertical reinforced steel joists (RSJs), secured to the RSJ by means of a metal bracket bolted to the concrete panel. On Hawkins Farm two concrete panels had been repurposed from another building to form a divide between a "collecting yard" (an area where cattle are held prior to be being encouraged into the milking parlour) and an adjacent barn where straw was stored, with one panel placed on top of the other, to form a wall that was approximately 6 feet in height. The concrete panels did not stretch between the two RSJs present. As a consequence, one side was secured using the above-described method, with the other side being secured using sections of steel "box" (hollow steel tubing) welded to the RSJ and "clipped" against the rear of the concrete panel using a metal bracket. On 30 th January 2021, Mr Woods was in the collecting yard when the upper concrete panel that divided the collecting yard from the straw storage came away from its fixing, causing multiple injuries to Mr Woods, who was sadly confirmed deceased at the scene.	

5	CORONER'S CONCERNS			
	The MATTERS OF CONCERN are as follows:			
	1. During the inquest evidence was heard that:			
	i. The sections of box tubing used to secure one end of the concrete panels to the vertical RSJ was a weaker method of securing the concrete panels in place, as compared to the method typically used (securing the panel directly to the RSJ using metal brackets bolted to the rear of the panel). They had been in place for a number of years and would have appeared to have been present when Hawkins Farm was subject to inspections by outside agencies, yet no remedial action was required.			
	2. I have concerns with regard to the following:			
	i. Pre-cast concrete panels are likely extensively used across farms throughout England and Wales. The equipment required to move panels between buildings is likely to be available on the majority of farms, meaning that there is a significant risk that farm owners/workers will move panels if necessary without the need to refer to external trades/professionals. As a consequence, there is a risk of the panels subsequently being fastened to vertical RSJs in a less secure manner, as occurred on Hawkins Farm. A collapsing concrete panel poses a clear risk of death, given their weight.			
	ii. There appears to be a lack of understanding of the importance of securing the panels in the optimal manner. It does not appear to have been understood by those working on the farm that the fixings that were used on the panel that collapsed were weaker, neither does it appear to have been appreciated by those that undertook inspections of the farm subsequent to the use of this weaker method of fixing. Publicising the risks and educating the farmers of the risks of departing from the recognised method of fixing the pre-cast concrete panels may reduce the risk of future deaths.			
6	ACTION SHOULD BE TAKEN In my opinion urgent action should be taken to prevent future deaths and			
	believe you and/or 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, Friday 14 th April 2023. 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) Trethowans Solicitors (solicitors for Mr Woods' family);(2) DAC Beachcroft (solicitors for Hawkins Farm Partnership).			
	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.			
9	Dated	Signed		
	17 th February 2023			
		Jos		
		Brendan J Allen		