	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. President, The Pipeline Industries Guild. 2. Chair, British Drilling Association.
1	**CORONER** I am James Bennett, H.M. Area Coroner for Birmingham and Solihull.
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 22 May 2023 I commenced an investigation into the death of Charles Harper. The investigation concluded at the end of the inquest on 11 January 2024.
4	**CIRCUMSTANCES OF THE DEATH** Mr Harper was involved in horizontal directional drilling and associated works, forming part of the HS2 high-speed railway construction project on land known as Sublot 5 Site, Land North of Hollywell Brook, Middle Lane, Birmingham. On 27 April 2023 ducting made from rigid 180mm poly-ethylene coiled pipe was being dispensed from a coil trailer through a pre-drilled 100 meter hole. Mr Harper was stood sufficiently close to the trailer, that at the end of dispensing when the stored energy was released, it caused the unsecured tail end of the coiled pipe to spring and strike Mr Harper causing serious abdominal and chest injuries, and he died the following day. The coil trailer was supplied with a restraining clamp and strap. The operating manual for the coil trailer, and method statement and risk assessment for the work, all identified the risk of the tail end of coiled pipe springing as a consequence of stored energy, and that it should be secured to the trailer. No such securing mechanism was utilised on 27 April 2023 and this contributed to Mr Harper's death.
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation the evidence revealed matters of concern, as follows: 1. A material number of drilling and pipe dispensing companies have in the past, and continue, to dispense coiled pipe without the use of any method of securing the tail end of the pipe coil, contrary to trailer operating manual instructions. 2. The use of exclusion zones may be insufficient alone, and provide a false sense of security, to guard against the risk of a worker being struck by the tail end of a coiled pipe springing in an unpredictable way when stored energy is released at the final stage of dispensing. The trailer manufacturer in this case indicated – although their instructions make it clear the tail end of coiled pipe should always be secured to the trailer, and that clamps/straps were effective in preventing springing of the tail end of coiled pipe - an intention to do further testing around the forces generated when stored energy is released, the effectiveness of clamps and straps to restrain the tail end of coiled pipe, and consideration of cages being installed around trailers; This will take some time and will require collaboration with pipe coil manufacturers and pipe coil dispensers. The HSE indicated the facts will be considered by the relevant sector division who will decide what if any pro-active health and safety action to take; This will also take some time.

	It appears to me that a number of drilling/pipe dispensing companies who do not always seek to secure the tail end of pipe coil during dispending, are likely to be members of either The Pipeline Industries Guild and/or British Drilling Association. Both organisations explain on their respective websites an aim is to improve the health and safety of its members. Both organisations are likely to be in a position to take action to alert their members to the risk. In my opinion there is a risk that future deaths will occur unless action is taken, you are in a position to take preventative action, and therefore in the circumstances it is my statutory duty to report to you.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 Tuesday 12 March 2024. 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 of England & Wales, and to the following Interested Persons: 1. Harper Services Limited. 2. The Harper family. 3. Morrison Water Services Limited. 4. Balfour Beatty Vinci Joint Venture. 5. Steve Vick International Limited. 6. Aviva Insurance. 7. Health and Safety Executive. 8. West Midlands Police. I have also sent it to the following who may find it useful or of interest: 1. ATE (UK) Ltd (The evidence was that alongside Steve Vick Internation Limited they are the other major manufacturer of coil trailers). 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	Signature: 

	James Bennett **H.M. Area Coroner, Birmingham and Solihull jurisdiction** **16 January 2024**