REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Bronia HARTLEY, Assistant Coroner, for the coroner area of Manchester West.
2.	**DATE OF REPORT** 22 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. S & G Properties (No.2) Limited 2. KMPM You are under a duty to respond to this report within 56 days of the date of this report, namely by August 17, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	I am concerned that: a. neither **S&G Properties (No 2) Limited** nor **KMPM** are following the Department for Communities and Local Government guidance for landlords and property related professionals in respect of the Housing Health and Safety Rating System designed to avoid, or at the very least minimise, potential hazards, in particular by ensuring that conditions are reviewed regularly to try to see where and how its properties or the properties it is managing can be improved and made safer; b. there are no clear systems in place at either company and at the intersection of the two companies to prevent the recurrence of circumstances such as those leading to the deceased's death, namely the development of a serious hazard *during* a tenancy which, as in the deceased's case, is reported but is not appropriately or timeously responded to, or which is not identified by the tenant, including in relation to: i. the categorisation of defects (e.g., urgent, structural, routine); ii. how structural concerns are escalated (including by way of the instruction of a structural engineer); iii. ensuring the timeous completion of works (and the implementation of interim measures, such as fencing off, where delay is envisaged); c. neither **S&G Properties (No 2) Limited** nor **KMPM** have carried out a post-incident evaluation of whether the properties owned and management by them respectively are free from serious hazards which remain outstanding and have not come to the attention of the Local Authority. and that these circumstances create a risk that other deaths will occur.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 23 July 2021 I commenced an investigation into the death of Clarice BERRY aged 77. The investigation concluded at the end of the inquest on 18 June 2026. The conclusion of the inquest was that: Clarice Berry died as a result of chest injuries sustained when the gable end wall and the upper part of the outer leaf of the end wall of her home collapsed onto her, in circumstances where the wall was affected by structural defects

	including wall tie failure of which there was clear evidence, and where no investigation or remedial works had been carried out, which, if undertaken, would have prevented the collapse. The medical cause of death was: 1a. Chest Injuries.
9.	**CIRCUMSTANCES OF DEATH** 1. On 18 July 2021 the deceased was doing something in the lean-to carport beneath the gable end of her home [redacted], when the entirety of the gable wall and the upper part of the outer leaf of the end wall (1.9m³ of brickwork with a mass of approximately 3,800kg) collapse, trapping her beneath the rubble. 2. The deceased suffered a severe fracture of the sternum and fractures to all her ribs. These chest injuries were incompatible with life and her death was diagnosed at 16:10 hours at Royal Albert Edward Infirmary. 3. The deceased lived at [redacted] with her husband [redacted] under a Rent Act protected tenancy which Mr Berry inherited from his father in 1964. 4. The property is an end-terrace. The end wall is a cavity wall but the gable wall above is solid. From 2013 onwards, the property had a number of recognised features of cavity wall tie corrosion: a. Cracking on the exposed south facing elevation (the gable end); b. A crack on the inside of the gable wall; c. Increased likelihood of cracking due to the presence of accelerating factors; and d. An outward bulge; together with the following accelerating factors: i. Acidic black ash mortar; ii. General exposure; and iii. Location in a (former) industrial area (where rain is more acidic). 5. From at least 2013, Mr Berry was concerned about bowing of the gable end wall and began pointing out the bowing of the wall to anyone attending the property who he believed to be associated in some way with the tenancy. 6. His report to the previous managing agent – Healy Simpson Limited – fell by the wayside because shortly following it, the property changed hands following the death of its previous owner and a new managing agent was instructed (Kaye Mackenzie). The new owner was S&G Properties (No 2) Limited. S&G Properties (No 2) Limited had a longstanding relationship with Kaye Mackenzie, which had managed

other properties owned by the company for decades.

7. On 6 August 2013 (nearly 8 years prior to the deceased's death), a property manager from Kaye Mackenzie visited the property and spoke with Mr Berry. Amongst other minor items requiring repair, Mr Berry pointed out the bowing or "bellying" end wall. The property manager recorded the following within the handwritten notes he made in respect of the visit:

   'Gable wall big bulge in wall – needs urgent repointing/+rebuild'

8. On 29 March 2016, same property manager visited the property again and made the following handwritten note:

   'Gable needs repointing'

9. Subsequent to this, others observed the bowing of the wall, such as a rent officer from the Valuation Office Agency and neighbours on the street.

10. Google Streetview images of the property in 2016, 2017 and 2018 show the gable wall. The images all show widened brickwork joints and bowing is clearly visible in the image from 2018.

11. Kaye Mackenzie was a partnership and in January 2020 the partnership was wound up. The abovementioned property manager retired but one of the former Kaye Mackenzie partners continued the property management side of the business as KMPM. KMPM continued to manage the same properties which had been managed by Kaye Mackenzie, including 9 Old Lane.

12. In around February or March 2021, a gas engineer visited the property to install a new boiler after the old one was condemned. The job took three or four days, during which time Mr Berry once again pointed out the bulge in the gable wall.

13. No works were done on the gable wall prior to deceased's death (not even repointing). Save as above, there was no monitoring of and no structural engineer or quantity surveyor was instructed to investigate the defective brickwork.

14. On 18 July 2021 the entire gable wall and upper part of the outer leaf of the end wall below collapsed as set out in paragraph 1 above.

15. The investigations carried out by HSE Specialist Inspectors following deceased's death revealed the complete failure of a series of wall ties in the upper part of the cavity wall below the gable wall. This is what accounted for the bowing which Mr Berry had been reporting since 2013.

16. The inquest heard evidence from a HSE Specialist Inspector that:

	a. the underlying structural problem was the failure of the wall ties; b. repointing might have slowed the progressive outward movement of the now unrestrained outer leaf of the wall, but without reinstatement of the connection between the inner and outer leaves, the eventual collapse of the wall was inevitable; c. if the wall hadn't collapsed when it did, it probably wouldn't have lasted another winter; d. any competent surveyor or structural engineer would have been able to identify wall tie failure and advise on remedial steps (which may not have even required a partial rebuild depending on the extent to which the outer leaf had peeled away). 17. I found that any reasonably competent property management company and/or responsible landlord would, at the very least, have ensured that the wall was monitored for any signs of progression and, by no later than 2018, would have ensured that a structural survey was performed. 18. I found that had such investigations been effected, on the balance of probabilities remedial action would have been taken and the collapse which caused the deceased's death would have been prevented. 19. The inquest explored with witnesses from **S&G Properties (No 2) Limited** and **KMPM** the systems in place now to ensure the identification and remediation of hazards which arise during tenancies.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: am concerned that: a. neither S&G Properties (No 2) Limited nor KMPM are following the Department for Communities and Local Government guidance for landlords and property related professionals in respect of the Housing Health and Safety Rating System designed to avoid, or at the very least minimise, potential hazards, in particular by ensuring that conditions are reviewed regularly to try to see where and how its properties or the properties it is managing can be improved and made safer; b. there are no clear systems in place at either company and at the intersection of the two companies to prevent the recurrence of circumstances such as those leading to the deceased's death, namely the development of a serious hazard during a tenancy which, as in the deceased's case, is reported but is not appropriately or timeously responded to, or which is not identified by the tenant, including in relation to: i. the categorisation of defects (e.g., urgent, structural, routine);

	ii. how structural concerns are escalated (including by way of the instruction of a structural engineer); iii. ensuring the timeous completion of works (and the implementation of interim measures, such as fencing off, where delay is envisaged); c. neither **S&G Properties (No 2) Limited** nor **KMPM** have carried out a post-incident evaluation of whether the properties owned and management by them respectively are free from serious hazards which remain outstanding and have not come to the attention of the Local Authority and that these circumstances create a risk that other deaths will occur.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **The family of Clarice Berry** • **Health & Safety Executive** • **Greater Manchester Police** • **Wigan Council (Private Sector Housing Team)** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Bronia HARTLEY** **Assistant Coroner for** **Manchester West**