REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Martin Clarke, Chief Executive, British Precast Concrete Federation.

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area of North and West Cumbria

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.

INVESTIGATION and INQUEST

On 12th September 2011 I commenced an investigation into the death of Martin Geoffrey McGlasson, aged 37. The investigation concluded at the end of the Inquest before a Jury on 20th December 2013. The conclusion of the inquest was:

The Cause of death was:

1.a. Multiple Injuries

The Conclusion of the jury was:

Mr McGlasson died as a result of an accident

CIRCUMSTANCES OF THE DEATH

Mr McGlasson was a plant operative employed by ACP Concrete Limited, part of Thomas Armstrong Holdings Limited, in Workington, Cumbria.

On the 2nd September 2011 he was slurrying a concrete staircase that had, that morning, been removed from a mould. The staircase had been transported by another operative by overhead crane and placed on its edge on two wooden battens on the floor. The staircase was not supported by the crane, or by other means whilst Mr McGlasson worked on it. He had slurried the back of the staircase and had started on the stairs side when the staircase fell on him, crushing predominantly his chest. The staircase was removed by use of the crane but it was clear that he was dead at the scene. The stairs weighed almost 3 tonnes. No one witnessed the accident.

The evidence was that the system of work, which had been in operation for 23 years without incident, was that:

1. After removal from the mould by overhead crane the staircase was set down on two or more battens (depending on the size of the staircase and any landings it had);
2. The operator would "sweep" the floor with the battens to ensure that they had no debris underneath, before setting the staircase down;
3. He would also seek to place the batten under the widest part of the stair to ensure maximum stability;
4. The operator would take the tension off the crane and then take hold of the top of the staircase and attempt to move, or rock it, it to check its stability. If he was concerned that it was unstable he would lift it and move the battens or the staircase;
5. Once satisfied as to stability he would remove the chains and leave the staircase, unsupported, to be slurried.
6. After the slurrying process had been completed the staircase was "rocked over" onto the forks of a forklift truck and then removed to the storage yard.

The evidence at the Inquest was that the method of work was followed on the day of Mr McGlasson's death. The work area was busy and the operative moved the staircase to what was considered to be an unusual place, in front of the joiners bench.

During the police and HSE investigation there was evidence of debris at the scene, such as small offcuts of plywood, screws etc, that may possibly have been under one or more of the wooden battens. It appears that the battens had been placed under the staircase at almost the narrowest part of the stairs rather than the widest part.

A specialist HSE Inspector gave evidence at the Inquest to the effect that in normal circumstances substantial effort, in excess of the power of one man, would be needed to push or pull over a staircase if placed properly on the wooden battens. However in this case the most likely explanation for the overturn was that there was debris under the battens. There was clearly concern why this instability was not felt by the operative when he put down the stairs, or Mr McGlasson as he was slurrying, and no explanation was forthcoming.

There had been, in 2003, a short attempt to change the method of work to ensure that the staircase was supported by the crane during slurrying. This was found to be impracticable, and was abandoned. They returned to the former method of work, as described above, and that remained in use until Mr McGlasson's death. However the Risk Assessments for several subsequent years and up until the death, which had been prepared by the Health and Safety Department at Thomas Armstrong Holdings Ltd showed that the method of work in operation was that the stairs were supported by the crane. There appears to have been no recognition by the managers, health and safety department or the supervisors of the difference in what was actually happening on the shop floor to what was said in the Risk Assessments.

Following Mr McGlasson's death the HSE immediately served a Prohibition Notice on ACP Concrete limited. Within a few days they had put in place a new method of work so that a "toast rack" was installed in front of each mould. These are steel pillars which slide into the floor and which support the staircases, which are also chocked, during the course of slurrying. The evidence at the Inquest was that the cost involved in building the "toast rack" was small, and its use has not appreciably affected the speed of the process. They do not make fewer stairs as a result of the new method of work.

Coincidentally there had been another accident at the ACP works on the morning of Mr McGlasson's death. A 17 year old had been rocking a small staircase onto the forks of a fork lift truck when the staircase rocked back at him and pinned his against the front of the mould. Fortunately a bolt sticking out from the front of the mould had prevented the staircase crushing his legs. As a result of this accident ACP Concrete have devised a method of overturning stairs after slurrying that does not involve men rocking the stairs onto the forks. They now transport the staircases by crane to a sloping gravel pit. Again the cost of installing the gravel pit was small and it has made no appreciable difference to the rate of production.

Not surprisingly the evidence at the Inquest was that the new method of work was much safer in that it eliminated the risk of injury or death in slurrying or finishing the staircase and then subsequently handling it.

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) The Health and Safety Director for Thomas Armstrong Holdings Ltd gave evidence that the method of work undertaken by ACP prior to Mr McGlasson's death is in widespread use throughout the industry. Thus a number of your members are at risk of deaths occurring in their establishments in similar circumstances to Mr McGlasson's death, and presumably at risk of having Prohibition Notices served on them by the HSE.

(2) Whilst the method operated had not apparently previously caused any accidents at ACP Concrete, evidence was given of an accident at Bison Concrete Products in 2002 involving the death of Mr David Jenkins. I understand that whilst it involved the overturning of a staircase, it occurred in a storage yard in a "domino effect".

(3) The method of preventing an accident as occurred to Mr McGlasson by installing a "toast rack" and gravel pit are inexpensive and do not affect production

(4) The risk of an accident occurring should be weighed in the balance with the potential injuries (which in this case are likely to be fatal or serious), and the cost involved in preventing such injuries (which in this case are very small). There cannot be any serious argument about affecting production.

(5) Care should be taken to ensure that Risk Assessments or their contents are disseminated or explained to the staff actually operating the process to ensure that what is being done on the ground is reflected in the Risk Assessment, and proper care given to then assess the actual risk.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the British Precast Concrete Federation has the power to advise your members to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 March 2014. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
[redacted] and her solicitors
ACP Concrete Limited and their solicitors
[redacted] of ACP Concrete and his solicitors
[redacted] of the Health and Safety Executive.

I have also sent it to the following who may find it useful or of interest:

The Cumbria Constabulary

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.

6th January 2014 **Signed:**