THE WEST LONDON CORONER'S COURT

IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF

ASHLEY MICHEL BULLARD

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Bendpak Inc 2. Liftmaster Ltd / Liftmaster Servicing 3. Precision Bodyshop Ltd, formerly Wheel Art Ltd 4. Volvo Car Corporation 5. International Organization of Motor Vehicle manufacturers (OICA) 6. The European Automobile Manufacturers' Association (ACEA) 7. The British Standards Institution
1	**CORONER** I am Michael Walsh, HM Assistant Coroner, for the coroner area of West London
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The inquest into the death of Mr Ashley Bullard, aged 32, was opened on 6th December 2018. The investigation concluded at the end of the inquest on 20th December 2022. The medical cause of death was: 1a Head injury The jury's Narrative conclusion to the inquest was: The car was placed by Ashley on outer pick up points, which was one of the set of points recommended by both Volvo and 'Autodata', the industry standard software. The lift was examined after the incident. A feature of the lift, namely freeplay within the arms, contributed to the car not being held by the lift. The combination of the alignment of the pads on the pick up points, the work being carried out on the car and the freeplay within the lift arms contributed to the car falling and as a result caused the death of Ashley Michel Bullard.
4	**CIRCUMSTANCES OF THE DEATH** Ashley died due to a vehicle leaving a Bendpak XPR9 2-post vehicle lift whilst he was working underneath it, at his place of work Wheel Art Ltd, now called Precision Bodyshop Ltd. The vehicle lift had been installed by Liftmaster Ltd, and was last serviced some 9 months before the incident, by Liftmaster Servicing. The lift had not been serviced in accordance with the Lifting Operations and Lifting Equipment Regulations 1998, nor maintained in accordance with guidance in the lift's

	installation and operating manual, and contained grade 4.8 bolts not intended to have been in use at that time. On 28.11.2018, Ashley used the vehicle lift to raise a Volvo S80 car using the outermost lift points, on or near the metal sill that formed the front user jacking points. As Ashley worked on the car, the alignment of the pads and the freeplay within the arms of the vehicle lift contributed to the frame contact pads moving from beneath a structural part of the car to a non-structural part that could not support the vehicle. This led to the car falling, causing Ashley fatal injuries.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters 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. – **Concerns directed to Bendpak Inc** CONCERNS Freeplay: 1. Evidence was given that it could be possible to reduce the degree of freeplay in Bendpak 2-post vehicle lifts. Given lift points positioned close to the edge of the vehicle may be in danger of allowing lifting pads / frame contact pads on the Bendpak XPR9 2-post vehicle lift and possibly other similar 2-post lifts, to move from a position under the structure of the vehicle, to a non-structural part of the vehicle, with a risk of the car leaving the vehicle lift, it appears the level of tolerated freeplay creates a risk of injury or death to those operating the lift. Lift pad adapter: 2. It is unclear whether a narrow vehicle lift point is suitable for 2-post vehicle lifts using frame contact pads, or whether a better fitted lifting pad adaptor is available. Evidence was provided by an HSE expert engineer, that some form of slotted vehicle lift pad would be better suited when using a 2-post vehicle lift to raise a car by way of the narrow outer lift points that are more often used with vehicle jacks. Warnings: 3. There are no warnings on the Bendpak XPR9 2-post vehicle lift or in its installation and operation manual, that suggests caution or a prohibition on using a 2-post vehicle lift in conjunction with the outer most lift points on the underside of vehicles, that may be positioned on or near the sill or seam of the vehicle and often within a few inches from a non-structural part of the vehicle for lifting purposes. Manuals: 4. At the point of providing suppliers / installers with the lift, Bendpak did not require any form of written confirmation of acknowledgment that suppliers received all manuals that Bendpak intended to provide, and considered important to the operation of the lift. It was unclear whether all such manuals were in fact provided. Evidence was provided by the Bendpak CEO [redacted], that if he had known the XPR9 lift had grade 4.8 bolts in the gear ring, he would have considered it required being taken out of service unless and until those bolts were replaced by grade 8.8 bolts. Bendpak issued, and Liftmaster supplied to its engineers, a Technical Service Bulletin Bendpak TSB 42-10201, that related to replacing the gear ring and bolts in lifts manufactured between 01.01.2010 and 01.01.2014, that may have replaced all grade 4.8 bolts with grade 8.8 bolts, and yet the XPR9 lift in question was manufactured on 14.07.2014 and still had slotted holes and a mixture of grade 4.8 bolts and grade 8.8

bolts on 28.11.2018.

Gear ring bolts:

5. There was no evidence as to whether all Bendpak XPR9 2-post vehicle lifts with grade 4.8 bolts had been recalled or whether grade 4.8 bolts had been replaced in all existing XPR9 lifts, nor any evidence as to what efforts had made to contact customers that might still have such lifts in operation, in order to replace grade 4.8 bolts in lifts manufactured after 01.01.2014.

6. The specification of the grade and size and torque settings of gear ring bolts provided by Bendpak prior to installation was not sufficiently clear within Bendpak's installation and operation manual, and appeared to cause confusion amongst engineers tasked with installing the lift and those required to service or maintain the lift.

7. It is not clear within Bendpak's installation and operation manual as to which components and bolts in particular, are the subsequent lift owner's responsibility to maintain.

Concerns directed to Liftmaster Ltd and Liftmaster Servicing

CONCERNS

Advice to lift owners:

1. There was little evidence of consistent practice amongst Liftmaster workers regarding informing the owners of vehicle lifts of the need to read the installation and operation manual, or in highlighting the important parts of the manual such as the need to tighten gear ring bolts. Liftmaster workers were not always aware that tightening a 'safety-critical' component such as gear ring bolts, were the customer's responsibility, and hence that was not communicated to customers.

Engineers reading the installation and operation manual:

2. An experienced Liftmaster employee gave clear evidence that he did not read all of the installation and operating manual for the XPR9 lift, in spite of being said to have received refresher training from his employer less than 5 months before giving evidence. He said he was not required to read the manual when he was trained, even though he had also signed a letter confirming that he had in fact read the manuals for the XPR series. At the time of giving evidence, he was unaware of the torque table and the full extent of the lift maintenance requirements within the installation and operation manual, notwithstanding the fact that tightening of gear ring bolts was considered by all relevant witnesses, to be critical to the safety of the vehicle lift. That employee was said to be presently employed by Liftmaster and Liftmaster was said to presently install and service Bendpak lifts.

Physical clearance surrounding lifts:

3. Photographs suggested the clearances recommended by the manufacturer, between the lift posts and the nearest obstruction, were not maintained at the time of the incident. Those clearances were said to be 13 feet at the front of the lift, 11 feet at the rear of the lift, and 5 inches from the sides to the nearest wall. Photographs taken very shortly after the incident, disclose the presence of a different vehicle within just a few feet of the rear of the lift used by Ashley in a neighbouring XPR9 vehicle lift / lift bay. It is unclear to what degree the recommended clearance requirements within the manufacturer's installation and operating manual were considered or adhered to at installation.

Concerns directed to Precision Bodyshop Ltd, formerly Wheel Art Ltd

CONCERNS

Adherence to operating manual:

1. There was no evidence that Wheel Art Ltd ever required vehicle technicians operating the Bendpak XPR9 lift, to read the installation and operating manual or to maintain the lift in accordance with the manufacturer's recommendations. I am informed that Precision no longer owns any Bendpak XPR9 lifts, but instead uses Hoffman scissor lifts. This concern is not focussed on the make or model of lift but the use of lift operating manuals.

Maintenance records:

2. There was no evidence that Wheel Art Ltd ever kept records of inspections, maintenance, or repair of the Bendpak XPR9 lifts in accordance with the Bendpak XPR9 installation and operating manual. Again, whilst Wheel Art Ltd may now use different vehicle lifts, this concern is not focussed on the make or model of lift but on the maintenance of relevant records.

Concern directed to vehicle manufacturers and associations

(a) Volvo Car Corporation

(b) **International Organization of Motor Vehicle manufacturers** (OICA)

(c) **The European Automobile Manufacturers' Association** (ACEA)

CONCERN

Outer lift points used with Bendpak XPR9 2-post vehicle lifts:

1. Volvo (and/or other manufacturers) appear to designate lift points towards the edge of vehicles, that are near, on, or outside the sill or seam of the underside of the vehicle. Lift points in a position so close to the edge of a vehicle frame, appear to be in danger of allowing frame contact pads on a Bendpak XPR9 2-post vehicle lift, and possibly other similar 2-post vehicle lifts, to move from a position under the structure of the vehicle, to a non-structural part of the vehicle, due to tolerated freeplay within the vehicle lift, leading to a risk of the car leaving the vehicle lift. Whilst multiple lift points are identified in manuals and/or on Autodata, no warning is given with regards to any danger of using 2-post vehicle lifts on the outer most lift points.

Concern directed to The British Standards Institution

CONCERN

British Standards on the degree of tolerated freeplay in 2-post vehicle lifts:

1. There appear to be no British Standards for the safe, acceptable and/or tolerated degree of travel or length of travel in terms of freeplay in 2-post vehicle lifts in the UK. Whilst evidence was provided by the HSE that the industry body SAFed suggested an acceptable degree of freeplay is the diameter of the vehicle lift's frame contact pad, it is noted that various 2-post vehicle lifts have different diameter pads, and hence there is no consistency in the amount of freeplay tolerated in 2-post vehicle lifts. It was also noted that the diameter of pad in the present case, at 130mm, could allow a frame contact pad, to move from a position underneath the structure of a vehicle, to a position under a non-structural part of the vehicle, which can cause the vehicle to leave the lift. An HSE engineer's expert evidence was that

	it might be more sensible for tolerated freeplay to not exceed half the diameter of the frame contact pad.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action in relation to the concerns above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th March 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. Ashley's family 2. Liftmaster Ltd and Liftmaster Servicing 3. Precision Bodyshop Ltd, formerly Wheel Art Ltd 4. Bendpak Inc 5. Health and Safety Executive I have also sent it to: Society of Motor Manufacturers and Traders (SMMT) [part of ACEA] and Garage Equipment Association Ltd, who may find it useful or of interest. 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	**11th January 2023**  **Michael Walsh** HM Assistant Coroner West London Coroner's Court 25 Bagleys Lane London SW6 2QA