

HM Senior Coroner Parsley
Suffolk Coroner's Service
Beacon House
Whitehouse Road
Ipswich
Suffolk
IP1 5PB

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Our Ref

Your Ref

Date

2026-0207

29/05/2026

Dear HM Senior Coroner Parsley,

Inquest touching upon the death of Allan Stevenson

We are instructed on behalf of [REDACTED]
[REDACTED] and write on its behalf in response to your report dated 6 April 2026.

[REDACTED] extends its condolences to Mr Stevenson's family and friends.

Prevention of Future Deaths ("PFD") report

We note the matters of concern set out in your PFD report and deal with these in turn below, which we were surprised to see directed at our client. At the conclusion of the Inquest, following submissions from Interested Persons, three recipients of the report were named, which did not include [REDACTED].

Prior to making a report you were respectfully invited to set out any concerns in respect of [REDACTED] which you chose not to do. As indicated during submissions at the Inquest, policies, controls, and procedures in place at the time of the Inquest were, and have been for some time, materially different from those in place in 2022.

[REDACTED]

Following any serious incident involving [REDACTED], the business takes the opportunity to reflect and learn lessons, and where appropriate, implement improvements.

Since October 2022, the business has undergone a name change from [REDACTED] [REDACTED]. This occurred in 2024 as part of a wider group restructuring to rebrand smaller regional businesses as [REDACTED].

A central Group Head of Safety, Health, Environment and Quality (SHEQ) was appointed to review and implement standardised policies across the group with a focus on continual improvement in health and safety.

The business is also now part of the National Highways Stakeholder Advisory Forum and the Traffic Management Contractors Association, supporting health and safety innovation and sector-wide best practice.

[REDACTED] notes the content of the evidence heard during the Inquest. This included confirmation that the Operative who installed the traffic management ("TM") plan had implemented arrangements that differed from the agreed plan.

The Operative was unable to provide any evidence that such changes had been authorised in accordance with the accepted process and [REDACTED] also found no evidence of authorisation having been given. Furthermore, the Inquest heard that none of the documentation that would accompany an agreed change had been produced.

The TM as implemented was inspected by a Network Inspector. The Inspector did not consider that the TM plan required significant change or that it ought to have been closed (which was an option available to him).

The Forensic Collision Investigator concluded that the LGV driver had sufficient opportunity to observe Mr Stevenson prior to the collision. The Investigator's view was that, once both Mr Stevenson and the LGV were on the roundabout, the primary contributing factor was the inherent blind spots associated with the LGV's design, rather than the TM layout.

Response to concerns raised

1. Complex schemes being 'flipped' on site:

Previous position:

The Inquest heard evidence that trained Planners designed TM plans based upon customer instructions and in accordance with the Red Book. Plans were checked by senior team members before being issued to customers in advance of the requested works for approval. Qualified Operatives then installed the temporary TM works in accordance with the TM plan.

The TM plan in question was sent to the customer 12 days prior to the works commencing and no issues were noted or changes requested.

Evidence was also heard that changes to the TM plan required appropriate authorisation from suitably qualified personnel (Planners). Accordingly, any requests by Operatives to amend the plan, whether arising from customer requests or initiated by the Operatives themselves, were required to be referred to Planners. The Planners assessed the request and determined if a job could be continued or needed to be cancelled.

Authorised changes would prompt the creation of further documents for 'job packs' where required. This included revised risk assessments and a new TM plan which would be issued to the Operative to implement. If the requested changes were not practical, the job would not proceed.

Whilst it is disputed whether the Operative who amended the TM plan received the required authorisation, evidence indicated that he was aware of a 'review system' or 'process' being in place at the time.

Updated position:

██████ now requires written customer confirmation that TM plans meet requirements before work commences which significantly reduces the potential for changes to be required on the day. In the absence of such confirmation, the job will not proceed.

Any requested changes prompt the plan to be reviewed and if necessary redrawn. Customer approval of the revised TM plan is required before the job can proceed. This requirement cannot apply to emergency response work where different considerations apply.

Material revisions to TM arrangements and schematics are now recorded in a Central Issues Register and monitored internally. Revisions are reviewed by the Group Head of Technical Standards, allowing updates to existing processes where necessary.

Further, ██████ has formalised its established processes around changes to TM on site, clarifying permissible on-site changes and the appropriate level of documented approval required for changes to plans. It also reinforces that, if in any doubt, staff should contact their supervisor. A failure to follow the process as set out in the policy document will result in disciplinary action.

This policy has been communicated to operational staff and is available to Operatives via a QR code present within all company vehicles.

Additionally, TM sites are now subject to random audits by supervisors to ensure compliance with plans and safe implementation. Whilst audits are random, they are generally completed based on the risk profile of the set up. A formal target is in place for site audits to ensure compliance with policies.

2. Escalation where an operative identifies a safety concern;

Previous position:

Processes dealing with requested changes (regardless of who made the request) are set out above.

Those responsible for planning and implementing the TM held relevant qualifications to undertake their roles. In relation to the material works, the changes suggested by the “*relatively junior TM operative*” were considered by the trained and qualified Operative during the Inquest. The Operative did not feel the suggested changes would have been practical.

Updated position:

As in 2022, suitably qualified and trained personnel plan, design, and implement temporary TM works. As part of the commitment to continual improvement, [REDACTED] WorkSafe (refusal to work) policy has been reviewed and updated. This confirms the circumstances in which work should not be completed if there are safety concerns and details what actions Operatives should take.

It makes clear that staff are not expected to work when:

- *They are not competent to perform tasks;*
- *The correct equipment is not available;*
- *There is no safe system of work;*
- *The site conditions have changed impacting the planned method of work; or*
- *The correct PPE is not available.*

In summary, the policy requires staff to cease work if they feel their safety or that of others may be at risk and to contact a supervisor to allow the work and method to be reassessed.

Additionally, [REDACTED] has introduced nine TM life-saving rules that form part of employees' inductions and are reinforced through briefings as well as visible posters. The rules include:

- *Ensure we are both qualified and competent to complete tasks;*
- *Stop work if anything changes and seek guidance; and*
- *Report all safety concerns to our supervisor/manager.*

These sit alongside the overarching golden rule of “*Stop, think, check – we never put ourselves in harm’s way ... a two second pause could prevent a lifetime of regret.*”

3. Special signage and cyclist-specific considerations:

Previous position:

All TM plans were designed in accordance with customer requirements and the Red Book. As such special consideration for cyclists within TM plans was already incorporated into [REDACTED] design process in 2022.

The Inquest heard evidence that the specific TM plan, as designed in line with the customer’s request, included instructions for cycle lanes to be closed and ‘special’, or bespoke signs to be used on site. These were set out on the plan as equipment required to be taken to site. This requirement was also detailed in the ‘front sheet’ or cover letter, of the ‘job pack’ provided to the Operative. They were not collected.

The signs would have been created at the depot where the Operative would collect all other required equipment. This process would have taken a short period of time. However, after the TM had been altered by the Operative on site the special signs would have been redundant. Had the Planner been notified new special signs could have been considered.

Updated position:

Planners share TM plans to Operatives directly via an application on their digital tablets in advance of the job. On every job, the ‘job pack’ now includes a separate ‘equipment list’ detailing all the required signage needed to implement the approved plan. This lists the equipment required which was available previously on the plan itself.

When plans require special signage, the Planners will share this request with the relevant local depot in advance of the job. The local depot considers if the signs are in stock or if they need to be ordered in advance of the works. If they are, they will be ordered.

Further, [REDACTED] has implemented the Design Guide for 'Cycle Safety in TTM Design' which sets out the specific considerations regarding cyclists for Planners when designing TM plans. This guide is easily accessible to all Planners when drafting TM plans.

4. Signage availability, spare equipment loaded onto vehicles:

Previous position:

The Inquest heard that a Local Authority Network Inspectors' role is to ensure that TM plans, as physically set out, comply with the Red Book. They do not receive or review the TM plans themselves. If the Network Inspector feels the TM arrangements on the ground do not comply with the Red Book they can raise their concern with the permitholder for the relevant works.

[REDACTED] does not consider it safe or appropriate to require operatives or Network Inspectors to utilise 'spare signage' to re-design TM schemes on site. It would be impossible to select the correct signs in advance as any issue with the TM is unclear until operatives are at site. This presents practical difficulties in terms of vehicle weight limits which may necessitate further operatives and vehicles increasing the footprint of the TM set up itself.

As noted above, both the Planner and TM Operative hold relevant qualifications. We respectfully submit it would be unsafe for Network Inspectors, who may not hold such qualifications, to request that signs are moved, added or changed, as this would amount to redesigning a TM plan which they may not be trained to do. This would likely necessitate a wholesale retraining of Network Inspectors nationwide.

Updated position:

As mentioned above, TM plans are approved in advance by customers to ensure they fit the requirements and equipment lists are prepared and shared in advance of jobs. As per the WorkSafe (refusal to work), change management policies and life-saving rules Operatives should not work unless it is safe to do so, as such, it is not anticipated that a situation should arise where the TM plan is amended, changed or redesigned with 'spare signage'.

Further, the powers of Network Inspectors are set by Central Government and outside of [REDACTED] control.

5. Communication with customers, permit holders and, where relevant, network inspectors:

Any system around Network Inspectors' access to information is a matter for Central Government.

██████ will continue to share best practice and look to improve health and safety practice across the sector.

6. Operation of Anglian Water's 'Defect Line'

██████ has no involvement in the operation or use of Anglian Water's 'Defect Line' and is therefore unable to comment on its functionality or use at the material time.

However, ██████ does and will continue to respond to any defects reported to it in a proportionate and timely manner.

Conclusion

The safety of ██████ staff and the public remains its highest priority. The business remains committed to ongoing learning and continual improvement to raise health and safety standards across the business and the wider industry.

We hope this letter helps to alleviate any concerns and demonstrates that significant changes were already in force prior to the Inquest. Such changes have been embedded through training, accessible documentation and are subject to ongoing audit and review to allow for ongoing improvements where opportunities for these are identified.

Thank you for taking the time to consider this response.

Yours faithfully

Clyde & Co Claims LLP