DWF LLP
1 Scott Place 2 Hardman Street Manchester M3 3AA DX 14313 Manchester
T 03333 20 22 20 F 03333 20 44 40 www.dwf.co.uk

Mr Chapman
HM Coroner
5 D & E Lakeland Business Park
Lamplugh Road
Cockermouth
Cumbria
CA13 0QT

By Post and By Email:
hmcoroner.northwest@cumbria.gov.uk

Your Ref: RC/SS/I/3/861/11
Our Ref: JVC/N50024/29882
Please quote this when replying
Date: 30 April 2014

Please ask for: [redacted]
Ext:
Direct Dial:
E-mail:
Direct Fax:

Dear Mr Chapman,

MR MARTIN MCGLASSON (DECEASED)
INQUEST 17 TO 20 DECEMBER 2013
RESPONSE TO REGULATION 28 REPORT

We write in reference to your Regulation 28 Report dated 6 January 2014 and further to our letter of response dated 3 March 2014.

To set the background, during the Inquest the evidence was that the system of work adopted by the Company 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, 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.

This system of work was an industry wide practice.

As a result of the Inquest your Report provided that we respond with actions we have taken which will help prevent future deaths (our actions being taken after advice and guidance being received from the British Precast Federation "BPCF).

Your Report set out that we provide a written response by Monday 3 March 2014.

We wrote to you on 3 March 2014 to request an extension of time for the Company to formally respond to the Regulation 28 letter. This was to allow us time to evaluate the British Precast Federation [BPCF] guidance which wasn't available at that point in time and make any additional and necessary changes to the Company's internal procedures and manufacturing process.

We understand the British Precast wrote to you on 28 February 2014 stating that it was taking its instruction very seriously and set out the actions it had already taken and a timetable for action.

The British Precast and its members confirmed they had already:-

1. Formally consulted and discussed with their product group the Precast Flooring Federation, whose members manufacture stairs.
2. Formally consulted and discussed with their product group the Structural Precast Association whose members manufacture stairs.
3. Visited ACP Concrete and the factory where the accident occurred to see the remedial measures installed.
4. Had extensive internal discussion regarding how to promote improved safety across the whole industry and beyond their membership.

The proposed timetable of their action, including actions completed was confirmed as follows:-

1. Consult and discuss with relevant parts of British Precast by 14 March including a meeting of our Health and Safety Steering Committee on 4 March and the next SHAD to be held on 11 March at Aggregate Industries, Hulland Ward factory, Derbyshire
2. Checking with Bison Concrete Products and past management for any related lessons from the death of Mr. Jenkins by 12 March.
3. Develop proposed best practice by end March 2014
4. Hold a consultation period on proposed best practice with HSE, within membership and also with manufacturers that are not members
5. Issue best practice guidance on May 1st at our AGM and conference PRECAST2014.

By way of background information British Precast is the trade association for UK concrete product producers operating permanent or long-term temporary manufacturing facilities. They have over 70 manufacturing members accounting for 70% of industry output. The British Precast target is to create a zero harm workplace for all.

We can confirm that [redacted] Managing Director of the Company with [redacted] (Group HS Director) and [redacted] Finance Director, met with [redacted] & [redacted] of the British Precast Concrete Federation. We can confirm that the circumstances surrounding Mr McGlasson's death, the subsequent investigation and the Inquest were discussed.

[redacted] and [redacted] of the British Precast Concrete Federation visited the Company premises at Workington. During this visit [redacted] and [redacted]

viewed and assessed the procedures and systems in place relating to the manufacture of precast stairs and in particular the restraining systems employed when stairs were stood on their stringer edges.

Subsequent to this meeting [redacted] also attended a BPCF safety meeting on 12 March 2014. This meeting had been called in relation to improving safety of the prestressing process where the British Precast have a task group working with the HSE. Part of the agenda of this meeting specifically related to the stability of stairs during their manufacture process and therefore was an opportunity to address the issues of stair safety

The BPCF has now evaluated all the evidence and has developed best practice guidance on safe factory finishing of precast concrete stairs. This guidance has been developed in consultation with:-

- The specialist product groups of British Precast – the Precast Flooring Federation and the Architectural and Structural Precast Association
- The wider membership of British Precast
- Non-members of British Precast as best they were able to do
- The Health and Safety Executive

The Company received draft copy of the BPCF Members Briefing Document No 11/2014 which sets out the best practice guidance. We can confirm that the Company has reviewed the briefing document and agreed to the implementation of its comments and guidelines.

We can confirm the best practice guidance is as follows:-

A risk assessment and safe system of work should be developed, communicated and agreed with all relevant staff. It is industry best practice to avoid placing stairs on their edge unless needed. If placing on edge is required then standard practice is:-

- *To support by craneage.*
- *To support by a restraint system (e.g. toast rack type system)*

A copy of the Members Briefing No: 11/2014 which shall be formally circulated by the BPCF on 1 May 2014 is enclosed.

The Company has listed below the actions implemented in relation to the precast concrete stair manufacturing process. Actions that were implemented immediately post the fatal accident and prior to recommencement of the stair manufacturing process:-

1. Immediate cessation of the practice of storing and working on staircases standing on their stringer edges without any means of restraint. The British Precast Guidance *No: 11/2014* specifically states that "*it is industry best practice to avoid placing stairs on their edge unless needed*".

2. Installation of the TOAST RACK stair support system, whereby the stairs are placed on their stringer edge between upright steel posts, including the placement of chock blocks for further stability before being released from the crane hooks and having subsequent

dwf

dressing works applied. The British Precast Guidance *11/2014* specifically refers to a toast rack type system as a suitable restraint system. The guidance states that "*If placing on edge is required then standard practice is:-*

- *To support by craneage.*
- *To support by a restraint system (e.g. toast rack type system)*

3. Immediate cessation of manually tipping stairs from their stringer stood edges to being laid flat on their soffit.

4. Installation of a TIPPING PIT whereby all stairs are to be transported from the TOAST RACKS to the TIPPING PIT, using the overhead crane, and purpose lifting points on the top edge stringer of the precast stair, where the stair is then slowly lowered into the gravel TIPPING PIT allowing the stair to rotate safely onto its soffit. All operatives including the crane operator are stationed at a safe distance external to the TIPPING PIT.

As a result of the death of Mr McGlasson and in light of the particular and unprecedented circumstance of the incident, other measures have also been taken, which include:

5. In consultation with the Precast Stair Department Operatives & Supervisors, the Risk Assessment was revised, and amended working procedures were drawn up to reflect the changes in working practices agreed including the Support and Turning of precast stair units as detailed above.

6. A series of further TOOLBOX TALKS were also held involving all those concerned in the Management, Supervision & Manufacture of Precast Concrete Stairs reflecting the revised Risk Assessment & Safe Working Method and a copy of these documents were issued to all those noted above. Subsequent to issue to all general operatives and supervisors in the stair department, further consultation took place resulting in adoption of an agreed safe system of work in the manufacturing process of precast stairs, from mould preparation to completion.

7. In common with the company's other processes, working practices in the staircase department remain under constant review, and the Company carried out a full formal review of all company practices and procedures, as well as and including a full formal review of all Management, Supervisors & General Operatives training including those relative to Health & Safety Management and Awareness. The process of review and consultation on safe systems of work, was rolled out to the production processes relating to all other products manufactured by ACP at the production facilities at Lakes Road Workington, Risehow, Maryport & Trafford Park Manchester, resulting in agreed safe systems of works being adopted.

8. A full review of all training accreditations was carried out and where applicable refresher training, new training and updated training methods were actioned. This included training specifically relating to Health and Safety awareness and management.

These were introduced through a series of internal training toolbox talks, using the newly adopted Risk Assessment & Method Statement as the basis. The Company also employed the services of external training providers for the training of supervisors and managers on health and safety awareness and management, including the Institution of Occupational Safety and Health [I.O.S.H] & obtaining certification of the International General Certificate in Occupational Health and Safety [N.E.B.O.S.H]

9. The Company has created a Safety Committee in order to improve and raise standards of health and safety at work. The aim of forming the committee is so that employees can approach their respective representatives with issues and suggestions, which the representative can then bring to the meetings and promote to the committee. It is intended that the Committee hold a meeting every 4 – 6 weeks. The attendees at this meeting shall include the three named representatives and two members of the management team. The nominated members of the management team are [redacted] the Production Manager and [redacted], the Group Health and Safety Director. If they are not available another member of the management team would be invited to participate.

10. The company wants to raise awareness of current safety standards set by the Company to prevent accidents and have introduced new procedures to achieve this. This involves a new starter review through which the Company will monitor, assess, instruct and train new employees. It is intended that every week at the supervisors meeting, safety issues are to be discussed including any accidents that have occurred.

The stated aim of the Company is the prevention of any re-occurrence of accidents.

Yours faithfully

DWF LLP