**IN THE SURREY CORONER'S COURT**

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**The Inquests Touching the Death of Peter William RICHARDSON**
**A Regulation 28 Report – Action to Prevent Future Deaths**

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| | **THIS REPORT IS BEING SENT TO:**<br><br>• **Penny Mordaunt, MP, Minister of State for Disabled People, Health and Work, (1)**<br>• **Safety Assessment Federation - SAFed (2)**<br>• **The Garage Equipment Association - GEA (3)**<br>• **Health and Safety Executive - HSE (4)**<br>• **HSB Engineering Insurance Services Limited - HSB (5)**<br>• [redacted] **(6)**<br>• **West End Garage -WEG (7)**<br>• **Liftmaster Ltd (8)** |
| 1 | **CORONER**<br>Simon Wickens HM Area Coroner for Surrey |
| 2 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009. |
| 3 | **INVESTIGATION and INQUEST**<br>The inquest into the death of **Peter William Richardson** was opened on the 4th December 2015 and was resumed on the 24th April 2017 before a jury. It was concluded on 2nd May 2017.<br><br>The cause of death was:<br>1a. Head Injuries<br><br>The conclusion of the jury was; Accidental Death |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 27th September 2015 Mr Richardson was using a Bendpak Two- |

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| | Post vehicle lift on behalf of his employer, West End Garage in order to work underneath a car. Whilst under the car, Mr Richardson was seen on CCTV to be fitting an under-shield. He was towards the rear of the vehicle when the car became dislodged from the lift and fell. The Car fell onto Mr Richardson causing head injuries that were fatal.<br><br>The Court heard evidence that the Lift Arm locking mechanisms were either not working at all or were not working as intended so as to allow movement or 'play' at the time of the incident. The responsibility for maintaining the lift rested with the operator who received instruction on the lift in 2012 at the point it was fitted, but not subsequently. Instruction manuals relating to this specific lift do not assist with tolerance levels or torque settings for safety critical elements.<br><br>The Court heard that under-shields on the Mercedes CLK and other cars present a clearance problem when lifted on two-post lifts as the size of the pad means it can extend onto the under-shield hampering its removal. The Court was told other items such as pieces of wood are often placed on top of the lifting pads in order to gain the clearance that is needed. It was said in evidence that anything placed upon the pad may be held securely by the weight of the vehicle, but could create further instability. Mr Richardson had used rubber blocks from another model of lift on top of the lifting pads at the time of the incident. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern and 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.<br><br>During the course of the inquest the evidence revealed that:<br><br>a) No formal guidance exists as to safe tolerances of safety critical elements of two-post lifts. The Court heard from two HSE witnesses and a 'Thorough examiner' who examined the lift for the purposes of complying with LOLER 1988, who gave differing views on what was a safe tolerance or 'play' for an extended lift arm. Further, it was accepted this was an issue of concern to the HSE, but as yet remained to be dealt with.<br>b) The supplier of the Bendpak Lift in the UK, Liftmaster, do not supply guidance as to the required torque for safety critical |

elements of their two-post lifts and neither do they provide guidance on safe tolerance levels.

c) Safe tolerance should be considered at a LOLER 'Thorough Examination' however there is no guidance to be followed and there is no requirement for such tolerance levels to be recorded and as such the levels are not available to any subsequent examiner.
d) Mr Richardson who operated the lift only received training on the specific lift at the point it was installed in 2012. All other users were subsequently trained by him in its use, which was not recorded and all users of the lift were expected to maintain the lift properly.
e) It is a known practice for a variety of different objects (for example a piece of wood) to be placed on top of the lift pads between the pad and the vehicle when it is lifted in order to provide clearance and to assist with difficult jobs such as removing a car under-shield.

**MATTERS OF CONCERN ARE**:

That consideration be given by (1), (2), (3) and (4) *[please see paragraph 1 above]* to:

1) Issuing guidance as to safe tolerance levels of safety critical elements on two-post lifts.
2) Implementing a system of recording tolerance and torque levels of all safety critical elements during a 'Thorough Examination' of a vehicle lift.
3) Implementing a system for recording such levels for comparison at subsequent examinations.
4) Either advising the industry that the practice of placing foreign objects between the two-post lift pads and the vehicle to provide the necessary clearance should not continue, or advising the industry how to provide such clearance safely when, for example, removing a car under-shield on a Two-post lift.
5) Implementing a system to ensure and to record that those operating a lift have been appropriately trained in its use and its maintenance and that they are periodically retrained.

That consideration be given by (8) to -

1) Providing appropriate and safe torque levels and tolerance levels of safety critical elements on Bendpak two-post lifts and others supplied.

That consideration be given by (5) and (6) to -

1) Implementing a system of recording tolerance and torque levels of all safety critical elements during a 'Thorough Examination' of a vehicle lift.

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| | 2) Implementing a system for recording such levels for comparison at subsequent examinations.<br><br>That consideration be given by (7) to -<br><br>1) Ensuring any member of staff operating a vehicle lift has received sufficient and appropriate training in the use thereof.<br>2) Ensuring each vehicle lift is checked on a daily basis by an appropriately experienced/trained member of staff and that all such checks are adequately recorded in writing.<br>3) Ensuring all vehicle lift manuals are available to lift operators at all times whilst at work.<br>4) Ensuring all vehicle lift operators use the pads made specifically for the lift being used and are instructed not to use any other object between the lift's pads and the vehicle.) |
| 6 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action. |
| 7 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES**<br>I have sent a copy of this report to the following:<br>1. Penny Mordaunt, MP. Minister for Disabled People, Health and Work<br>2. Health and Safety Executive - HSE<br>3. Safety Assessment Federation - SAFed<br>4. The Garage Equipment Association - GEA<br>5. West End Garage - WEG<br>6. HSB Engineering Insurance Service Ltd - HSB<br>7. [redacted]<br>8. Liftmaster Ltd<br>9. [redacted]<br>10. The Chief Coroner |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br>The Chief Coroner may publish this report and / or the responses in a complete or redacted or summary form. Further, 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. |
| | **Signed:**<br><br>*Simon Wickens*<br><br>**DATED this 10th May 2016** |