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Operating company of Royal BAM Group nv

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Date:28.04.20

Your reference:

Our reference:

Tel: [redacted]

Inquest touching the death of Gary Dean Webster – response to Regulation 28 Report

Dear Sir

As you are aware, I gave evidence at the resumed inquest touching the death of Gary Dean Webster and wanted to formally respond on behalf of BAM Nuttall Limited ("BAM Nuttall") to the Regulation 28 Report to Prevent Future Deaths dated 2 March 2020.

I begin this letter by reiterating both my deepest sympathy and condolences, and those of BAM Nuttall, to Mr Webster's family.

The conclusion of the inquest was that the medical cause of death was as a result of cold water immersion which led to cardiac arrest and later multiple organ failure. The Jury returned a narrative conclusion.

Following the inquest, you raised three discrete concerns in your Regulation 28 Report, and invited BAM Nuttall to respond. I have answered each of these areas in turn:

1. Risk Assessment

The Coroner identified the following concerns:

1. *the failure of the Senior Engineer and Manager involved to appreciate the hazards involved*
2. *require a suitable and sufficient assessment of the risks involved before proceeding*
3. *consider whether alternative methods of accomplishing the task might reduce or eliminate the risks to their safety*

The Coroner heard evidence that a dynamic, point of work risk assessment was carried out by the site foreman immediately prior to Gary entering the weir on the Dory boat. It is accepted by BAM Nuttall that this was not a formal written risk assessment and was not supported by a method statement to carry out the work activity, unlike all of the very carefully planned and executed tasks on site that day – the inquest heard about the dive plan and the maintenance to the bladders which were being undertaken and for which in line with BAM Nuttall's procedures, trained and competent engineers carried out detailed written risk assessments, with input from the site foreman and other site workers.

There have been some changes in personnel in the two and half years since Gary's death. Refresher training has either already been provided or has been scheduled to be provided to all of those who are in roles where they might be expected to undertake risk assessments to ensure the high levels of competence expected by BAM Nuttall remains current and front of mind, as part of BAM Nuttall's ongoing training provision. Separately, BAM Nuttall's dedicated health and safety team has again circulated information relating to the incident to the wider business, highlighting the need for carrying out risk assessments when undertaking new or unfamiliar work activities.

Immediately following the incident, BAM Nuttall considered whether the activity of clearing out debris from the area in front of the curtain of water was a necessary task at Knostrop Weir. It was concluded that the debris was a cosmetic eyesore, but posed no risk of damaging Knostrop weir. As such, the activity was not a required activity and was subsequently banned on both the local site and all BAM sites. We determined after a further review that the activity could not occur at any other BAM Nuttall site; this learning has been recorded to ensure corporate learning in the future.

Since the incident, BAM Nuttall has consolidated its processes and procedures in respect of working over or near water in its guidance document "SG16". This guidance has been trained out to all relevant BAM Nuttall employees and contractors. The basic principle is to ensure zonal working is implemented on sites such that high risk areas are classed as prohibited entry. I can confirm that the area under an operating weir would be classed as a prohibited area using this system. As such, workers will not ever be permitted to enter the area.

2. Qualifications

The Coroner raised two concerns relating to qualifications. The first was in relation to one site worker who was not trained to operate the boat involved in the incident and the second related to Gary Webster's own qualifications.

In respect of the site worker who was not competent to operate the boat, I can confirm BAM Nuttall operates a strict policy of disciplining individuals if they operate equipment when they are not competent to do so. In some cases this would result in instant dismissal. In this instance, whilst the operative himself stated he had previously operated the boat, this is disputed and would have been put to him as untrue if he had attended the inquest in accordance with his witness summons. Were it the case that the operative was found to be operating the dory boat without being qualified and authorised to do so, he would have been guilty of gross misconduct and would have been disciplined immediately. There is a clear prohibition on untrained operators using pieces of equipment which they are not authorised to work. All Site Operatives and contractors are reminded of the site rule that they may only operate equipment that they hold the appropriate qualifications and competence to do so. This is enforced through supervision and disciplining at site level.

In relation to permitting, there is no one stop shop as an industry standard. There is no "permitting" system mandated in any ACOP or guidance note. Site operatives either hold a "ticket" for a particular piece of equipment, or they do not. If they hold a ticket and can demonstrate they are competent under the supervision of a site foreman, then they are deemed competent to operate that equipment on site. This is recorded and managed at site level.

Gary Webster's qualifications were checked at the outset of his commencing work at Knostrop Weir. BAM Nuttall believe Gary was a competent boatmaster with significant experience of working on water. Gary Webster's experience was respected on site; he was known to identify and rectify issues with methods of work and the evidence given at the inquest, including by his family, was known to refuse to work if he felt the method was not suitable.

In respect of the Coroner's second concern around qualifications, the Coroner heard conflicting evidence about whether Gary Webster had previously operated the boat involved in the incident. BAM Nuttall is unable to reconcile that evidence. However, I can confirm that in my opinion, Mr Webster's qualifications were suitable for his role on site and it would not be industry standard to ask for any additional qualification.

The site foreman and site supervisors are aware of and keep a record of which operatives are competent to operate which machinery and equipment. In this case, the instruction to operate the boat was given to Mr Webster, who as set out above, was competent to operate it. It is not clear how an additional physical marker (such as a different colour hard hat) would assist in identifying a competent individual and indeed on a complex site with many pieces of specialist equipment it may even cause confusion to site workers.

3. Design of the weir installation

BAM Nuttall was not involved in the design of the weir installation. As such, I am unable to comment on this further, except to confirm that BAM Nuttall will ensure that the Coroner's Report to Prevent Future Deaths is shared at the earliest opportunity with any designers of weirs in projects for which BAM Nuttall is acting as Principal Contractor.

BAM Nuttall is committed to the ongoing training of its workforce, as well as the ongoing development of ever safer systems of work. To that end, the business has carefully considered the concerns raised by the Coroner and is satisfied that similar circumstances cannot arise again.

Yours sincerely

[redacted]
Director, Health and Safety
BAM Nuttall ltd