ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **BAM Nuttall Limited** 2. **BMM JV Limited**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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.
3	**INVESTIGATION and INQUEST** On 2nd November 2017 an investigation was commenced into the death of Gary Dean Webster, aged 60. The investigation concluded at the end of the Inquest on Thursday 27th February 2020. The conclusion of the Inquest was a Narrative Conclusion, the medical cause of death being:- 1(a) Multiple organ failure 1(b) Cardiac arrest 1(c) Cold water immersion
4	**CIRCUMSTANCES OF THE DEATH** On Monday 30th October 2017, Gary Dean Webster was working as a boatman at the site of a Flood Alleviation Scheme Civil Engineering Project on the River Weir where three weir gates had been installed. He was instructed to retrieve a propane gas cylinder which was swirling in the turbulent water at the front of a 2.6m water cascade at weir gate number 2. He and another man approached the area in a flat bottomed boat for this purpose. The boat became embroiled in the turbulent water and capsized. The other man managed to get clear but Gary Webster was immersed in the cold water for some 15 minutes before being rescued from the river. He had suffered a cardiac arrest which gave rise to multi organ failure and died in Leeds General Infirmary on 1st November 2017.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to concern. 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. The **MATTERS OF CONCERN** are as follows. – (1) To retrieve the gas cylinder the two men approached a hazardous area of turbulent water, without a formal risk assessment having taken place or a

method statement approved.

The two men involved had not undertaken this task before. It required them to approach a hazardous area of turbulent water. Despite this they were permitted to proceed without a risk assessment being undertaken or a method statement being approved. The task was merely delegated to them and they were left to devise a method for themselves.

The concerns arising from this are (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 and (3) consider whether alternative methods of accomplishing the task might reduce or eliminate the risks to their safety.

Such an approach to inherently hazardous tasks gives rise to the risk that another death may occur in the organisations named due to inadequate planning procedures.

(2) A permissioning system was in operation at the site which restricted the operation of the safety boat to identified persons who had been trained and authorised.

Despite this, the safety boat was being operated at the time of the incident by a worker who was neither authorised nor trained. He had operated the boat on previous occasions but had no experience of doing so in the turbulent water conditions encountered. Whilst he was controlling the boat it became engulfed with water cascading over the weir and overturned.

A second aspect of this concern relates to Gary Webster who was expected by the Works Manager to be operating the safety boat and hence can be inferred to be expressly authorised to do so.

He was qualified and had many years' experience operating large boats. It was assumed that by virtue of qualifications obtained elsewhere on other vessels that he could be taken to be competent to operate a small craft such as this safety boat. The evidence taken at the Inquest indicated he was not competent to operate the boat's outboard motor.

These factors indicate that the permissioning system was ineffective on 30/10/17. The concern here is that unless a permit system is enforced, with appropriate checks made to verify credentials, a further death may occur if individuals are allowed to stray beyond the boundaries of their competence.

(3) It was a known phenomenon that flotsam and debris would float down the River Aire, pass over the weir gates on occasions and then remain in the vicinity of the swirling water at the foot of the 2.6m cascade at the weir gates. Such debris may create the potential for monitoring devices near the weir gates to be damaged or cause environmental harm.

Such a phenomenon should have been foreseen at the time the weir installation was designed. If it was deemed necessary for debris to be removed then a safe working platform should have been incorporated into the design in order that the task of retrieving offending items could be accomplished without workers being exposed to the hazard of working in close proximity to turbulent water. Alternatively, a procedure should have been devised to enable debris to be freed by the operation of the steel weir gates or underlying neoprene bladders.

The concern here is that shortcomings in the designs of this nature may expose workers to potentially fatal risks in the course of future maintenance tasks.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th April 2020 (to allow for the intervening bank holidays). 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) Leeds City Council – FAO: [redacted] (2) [redacted] Brother (3) [redacted] (4) HSE – FAO: [redacted] (5) West Yorkshire Police – FAO: [redacted] I have also sent it to ARUP + Partners 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	**Dated: 2nd March 2020** **Signed:** Kevin McLaughlin