

FATALITY AT UPPER LODGE LOCK OCTOBER 2004**(1) OUTCOME OF HSE PROSECUTION****(2) MANAGEMENT ACTIONS SINCE FATALITY****Report by Corporate Services Director****1. PURPOSE**

- To confirm the outcome of the prosecution, initially notified by e-mail;
- To summarise the actions taken in response to the fatality, from the immediate aftermath, through the prosecution and after.

2. OUTCOME OF HSE PROSECUTION

Three defendants were prosecuted by the HSE in connection with the death of a contract diver in October 2004 whilst undertaking a diving operation at Upper Lodge lock on the River Severn. The defendants were (i) Sea Technical Services Ltd (STS), the diving contractor company; (ii) Christopher Drake, the sole director of that company and the diving supervisor; and (iii) British Waterways.

All three defendants pleaded guilty to offences under the Health & Safety at Work Act and regulations made under that Act. The key offence as far as BW was concerned was failing “to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.” BW was fined £80,000 for that offence and a further £7,000 for breaches of two regulations. STS and Mr Drake were together fined in total £21,000. In setting the level of fines the Judge had to take into account the defendants respective financial resources.

3. SENTENCING REMARKS

HH Judge Horton was critical of all defendants and his criticisms of the conduct of BW focused on the failure of those managing the works to comply with existing procedures that the Judge acknowledged BW had in place. In particular he was quite trenchant in his criticism of the inadequate risk assessment and a failure properly to take heed of information from an earlier inspection. In sentencing he gave credit to BW for the guilty plea; for facilitating investigations with a costly de-watering of the incident site; and for its post incident safety record.

4. BW INVESTIGATIONS

Immediately following the incident, in addition to providing extensive support to the Police and HSE investigations, BW commissioned its own independent expert investigation and report from Evans Grant Opus (EGO), consultant engineers and diving specialists. The investigation was hampered to a degree by the Police/HSE seizure of all project documentation. EGO provided a draft report in February 2005 and a final report in June 2005.

EGO considered the then BW diving operation procedures sound but nevertheless updated them for BW. Denied access to the BW project documentation, the EGO report focused on the events as known and was particularly critical of the diving supervisor ordering a dive against the differential head. BW management nevertheless identified weakness in professional engineering leadership and oversight of safety issues at the business unit and the senior business unit engineer was replaced. The following spring a new Head of Safety was recruited with extensive experience in higher risk environments (inc. offshore & mining).

5. PROSECUTION / INVESTIGATION CHRONOLOGY

- Date of incident – 14 October 2004;
- EGO Report (for BW) – 1st draft February 2005; Final Report June 2005;
- Coroners Inquest – 14 to 23 May 2008;
- Summons served - 6 April 2009;
- Guilty Plea entered - 15 June 2009 (Magistrates Court); and
- Sentencing Hearing (Crown Court) – 24/25 September 2009.

The long delay to the HSE prosecution process not only caused great distress to the victim's family but also handicapped BW in addressing detailed investigation of causation and any individual responsibility. This was primarily due to lack of access to documentation but also, because local operatives and the supervisor had been interviewed under caution and were therefore at risk of individual prosecution, any disciplinary action had to be on hold until the prosecutors' intentions were known.

It did not however delay the implementation of the generic Safety Transformation Programme which had been launched 4 months before the incident (further described below).

The first significant insight into the detailed chain of causation came at Coroners Inquest with a partial disclosure of documentation and expert evidence held by the HSE. Service of the prosecution summonses did not however take place until almost a year later. BW was not entitled to full disclosure of all HSE held evidence until after its guilty plea and even then the HSE sought to withhold certain of their expert evidence relevant to causation.

It was only towards the end of the above chronology that the prosecution case on causation changed significantly from one that focused (in the case of BW) on its methodology and equipment design to one that focused on the application and implementation of that methodology by the project team.

6. BW ACTIONS IN RESPONSE TO THE INCIDENT

As already mentioned above, the Business Unit senior engineer and national Head of Safety were both replaced within 9 months of the incident (the former earlier). The non-professional employees supervising the works at Upper Lode are still with BW but are now in positions with where they do not have responsibility for works of the scale of the Upper Lode works. They have since the incident been part of the Safety Transformation Programme that has involved the whole workforce.

Remedial action in respect of BW's safety record and culture had already begun prior to the incident. In 2003, primarily because of issues concerning the safety performance of BW, the then Technical Director was replaced and in April 2004 and Safety Transformation Programme was begun. The role of Responsible Line Manager (RLM) and a revised safety policy was introduced setting out BW's new approach to H&S management. The Upper Lode Incident (and the K&A tractor incident before it) gave extra momentum to the roll out of the Programme.

Specific corporate actions to support RLMs have been:

- Introduction of best practice diving procedures and specific role of Diving Contract Administrator (DCA) to ensure BW's "Client" role is properly fulfilled. DCAs are trained by External Diving Experts on an intensive 4 day course. Use of pre-qualified diving contractors only (pre-qualification through the professional body The Association of Diving Contractors) following Upper Lode
- Introduction of 'manager of contractors' role and supporting processes to pre-qualify contractors and actively manage their activities on BW property.
- Introduction of revised risk assessment procedure in Mar 2005. Retraining of all supervisors in risk assessment and "setting to work" employees and contractors
- Launch of 'Point of Work' risk assessment process in November 2005 (requiring a "Stop and Think" approach to work and particularly empowers front line employees to stop the job if they feel it is unsafe to proceed)
- A requirement is placed on managers to audit H&S at worksites. Audits are scheduled and monitored through leading H&S KPIs with report back and follow up action, introduced in Monthly measurement and reporting of safety management inputs through the "leading" safety KPIs
- A behavioural safety program for managers to complement the one already in place with the workforce was introduced in 2008.
- Robust internal audits of compliance with processes and procedures.
- The introduction of compliance checklists and more rigorous monitoring of compliance with standards using BWISE software commenced in 2009
- Review and publish all (Red Star) safety instructions - completed in Sep 2009

In addition to continuing with the Safety Transformation Programme, a fresh short term but maximum impact initiative, drawing on the lessons learned from the Upper Lode incident is being planned with a senior management steering group (Messrs Moran, Stirling and Johnson) meeting on 12 November. It is likely this will take an alternative but complementary approach to the safety transformation programme.

It is also relevant to mention that the design of the corporate restructure recently implemented was significantly influenced by this incident with the removal of much of the former local autonomy and introduction of shorter and more direct lines of accountability to executive directors.

7. SUMMARY

- BW's safety culture and record has moved a very long way forward since the incident.
- The Judge in his sentencing remarks recognised BW had appropriate procedures in place but criticised the supervisor's and operatives' failures to follow them as well as the failure in oversight by the relevant professionals.

- One engineering professional and the then head of safety were replaced soon after the incident.
- Other of the employees involved have different duties.
- The incident gave extra momentum and urgency to the Safety Transformation Programme that was being rolled out when it occurred and has been in continuous use, refreshed as necessary, in the intervening five years.

10 November 2009