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MARCH 2007

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IN THE COURTS

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The HSE has warned companies that they risk enforcement action if they continue to pursue poor management systems.

The warning follows the prosecution of two companies at Nottingham Crown Court. Bau GmBH, of Angelburg in Germany and Re-Construction UK Ltd of Quebec Quay in Liverpool were both sentenced at Nottingham Crown Court following poor management during the construction of the Lidl store on Mansfield Road in Nottingham during November 2005. Bau GmBH was fined £100,000 and costs of £6,188. Re-Construction UK Ltd was fined £50,000 and costs of £6,188.

HSE Inspectors visited the Lidl site on 11 November 2005 and on three further occasions following nine complaints from members of the public. Investigations revealed the site was not being effectively managed. Three prohibition notices were served to stop the most hazardous activities from being carried out including dangerous working at height and vehicle and pedestrian segregation, safety of excavations, failure to wear the correct PPE, movement of loads around the site and fire safety. As well as the obvious risks to the safety of those on site, there were also potential risks to members of the public.

HSE Inspector Martin Giles said: "*Our inspections revealed a number of areas that were highly dangerous. The site was not being effectively managed and the contractors had highly cavalier attitudes that showed a reckless disregard of health and safety procedures and requirements. Workers were being left to do work without adequate supervision, untrained workers were having to make important decisions and there was no proper coordination to ensure that they would be working together safely. The contractors should have ensured scaffolding was safe and ensured suitable edge protection - this had been removed in some areas whilst there was still roof work taking place. Scaffolding was also set up in an excavation and there was a risk it might collapse with a worker underneath it. There were also areas that were not adequately protected to prevent anyone falling in. They should have ensured workers were wearing head protection while on the site, ensured all emergency exits were clear and ensured safe use of ladders. What makes this site so unusual and so dangerously unsafe is the sheer number of the hazards - all of which would have been simple to resolve. Contractors are expected to organise health and safety effectively and take appropriate measures. Where standards are poor, HSE will prosecute those responsible, even if there has been no injury, as in this case.*"

Appearing in court, Bau GmbH were sentenced for contravening Section 2(1) and 3(1) HSWA 1974. The total fine was £100,000. Reconstruction UK Ltd was sentenced for contravening Section 3(1) of the Health and Safety at Work etc Act 1974. The total fine was £50,000. The costs for both firms were £12,376.

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BATH NHS TRUST FINED FOR LEGIONELLA RISKS

The HSE has prosecuted the Royal United Hospital, Bath, NHS Trust, sending a clear message to all NHS Trusts that they must beware of the dangers of Legionella bacteria and control the risks accordingly.

Bath RUH NHS Trust was prosecuted at Bath Magistrates' Courts on 20 March, under the Control of Substances Hazardous to Health Regulations 2002, following the death of a patient in February 2004 from Legionnaires' disease contracted whilst he was a hospital in-patient. Sentencing took place at Bristol Crown Court on 29 March 2007.

The Trust pleaded guilty to both charges and was fined £40,000 for Regulation 6 and £40,000 for Regulation 7 of the COSHH regulations. It was also ordered to pay full costs of £23,883.

HSE Inspector, Susan Chivers, who investigated the case, said: "*This prosecution sends a clear message to all NHS Trusts that they need to assess the risks of Legionella bacteria in their water systems and put in place measures which effectively reduce these risks. They particularly need to ensure that their risk assessment takes into account the vulnerability of certain patients, such as those with reduced immunity to infection.*

Keeping the risk assessment up-to-date is vital - so whenever changes to water systems or to the use of Trust buildings are planned, then risk assessments and control measures need to be updated accordingly. Additionally, control measures need to be properly monitored to ensure that they continue to be effective. Protecting the health and safety of patients, visitors and employees in this way is a responsibility Trusts must take seriously - not to do so can have fatal consequences."

HEALTH AND SAFETY IS NOT A MATTER OF ARTISTIC IMPRESSION

Working at height without taking proper precautions risks disaster. Following the serious injuries of a contractor and member of the public at the University of the Arts London John Preston and Graham Cresswell were each fined £7,500 after pleading guilty to breaching Section 3(2) HSWA 1974 and the University of the Arts London was fined £20,000 (the maximum fine in the Magistrates Court) after pleading guilty to breaching Section 3(1) of the HSWA. Costs of £9654 were awarded to HSE.

HSE Inspector Dominic Long said, "*This case should act as a wake up call to all firms engaged in working at height to properly consider the serious risks involved. This was an accident which very nearly killed a young man and a member of the public. The accident happened on one of the busiest shopping streets in the UK and it was sheer luck that more people were not killed or injured. It was entirely preventable - had the contractors and the University cooperated with each other in assessing the risks and planning the work being carried out it is very likely that this accident would have been avoided. Every year people working at height lose their lives or suffer serious injury and firms need to exercise sufficient control to prevent this sort of thing happening - including carrying out a proper risk assessment.*"

Jeremy Davenport suffered multiple injuries including a shattered heel and a broken pelvis when he fell over 5 metres from a ladder he was using for access to a ledge located above the busy shopping area of Oxford Street. He fell onto the ledge and from there to the ground. The ladder he was using also fell from the ledge and struck a member of the public Ms Desislava Ilieva, who was walking underneath at the time. She suffered head and back injuries.

BRICKLAYER'S DEATH

Blackpool firm R P Tyson Construction Ltd was fined £16,000 and ordered to pay £6,446 costs at Preston Crown Court after pleading guilty to a charge under HSWA. The case followed the death of its employee Anthony Isherwood during construction work at Hutton Grammar School near Preston on 29 November 2004.

HSE Inspector Roger Jamson said: "*Tony Isherwood was working on the conversion of a gymnasium into classroom space following construction of a new gym elsewhere on site. Part of this work involved building a mezzanine floor supported by steel beams that had been put into place over the previous few days. Packs of corrugated steel floor decking had been temporarily placed on the beams ready to be laid out at a later date. In the morning Mr Isherwood had started fixing the beams into place but before this was completed he moved to ground level where, with others, he started to build a wall, intended to support the flooring between two of the beams. An all terrain lift truck was being used to bring materials into the gym. When this reversed its mast struck one of the steel beams, which was supporting a pack of floor decking, as one end of the beam had not been fixed into place this caused steel decking to fall onto Mr Isherwood and crush him. He died at the scene a short time after the incident.*"

Mr Jamson added: "*In common with many accidents the death of Mr Isherwood had a number of underlying causes, the identification of any one of these factors would have prevented this tragic incident. It is important that anyone in control of a construction site assesses the particular risks involved at their specific site of work and that this is kept up to date as circumstances change.*"

DURHAM COUNTY COUNCIL FINED

Durham County Council was fined a total of £20,000 for 5 health and safety offences arsing from an incident in which a 100-tonne mobile crane overturned into a culvert where men were working.

The incident occurred on 1 August 2005 in Front Street, Pelton Fell, County Durham, when the council was constructing an extension to an existing culvert and repairing the head wall of the culvert.

HSE Inspector Michael Brown said: "*The council ordered a crane and operator from contractors to lower materials into the culvert where they were working, which was about 30 metres below road level. A 60-tonne crane was sent to the site but did not have sufficient reach, so a 100-tonne crane was sent. Its outriggers were placed on the earth at the top of the embankment where there was insufficient bearing capacity. The ground gave way and the crane toppled into the culvert. It missed the five men working in the culvert by no more than five metres. The site manager had been called away and the foreman who was left in charge did not have training or knowledge of lifting operations, and the operation was not properly planned or adequately supervised. In addition, a nearby public footpath from a housing estate to Front Street had not been closed off, though there is no evidence that members of the public were in the vicinity at the time*".

The council was fined £7,000 each for failing to ensure the safety of its employees; and failing to ensure that people affected by their work but not employed by them were not exposed to risks; and £2,000 each for failing to ensure every lifting operation was carried out in a safe manner; failing to ensure every lifting operation was appropriately supervised; and failing to ensure every lifting operation was properly planned. It admitted all the offences. The council was also ordered to pay £3,103 costs.

FALLING FOLLIES

Hough Engineering Ltd was fined £20,000 and costs of £10,000 at Stoke on Trent Crown Court following an accident which resulted in Mr Andrew Cotton, an employee, falling 6.2 metres through a fragile skylight. Mr Cotton sustained serious injuries including multiple fractures.

Josiah Wedgwood and Sons Ltd were also prosecuted and fined £60,000 and costs of £17,837 for contracting Hough Engineering Ltd to undertake work to a warehouse when they failed to control of the contractors at this remote site.

Prosecuting HSE Inspector, David Brassington said: "*Experience shows that falls from height usually occur as a result of poor management control rather than because of equipment failure. On this occasion the roof repair activity was allowed to commence without the provision of any precautions, such as close hung safety nets and platforms with edge protection, which would have prevented the fall. Companies need to realise the necessity of implementing appropriate safety measures and management systems to provide a safe working environment, preventing falls and avoiding injury*."

The accident occurred on 6 May 2003 when Mr Andrew Cotton from Newcastle under Lyme fell through a fragile skylight whilst undertaking roof repairs as an employee of Hough Engineering Ltd of Silverdale, Newcastle under Lyme. The accident happened at Josiah Wedgwood and Sons Ltd warehouse at Parkhouse Industrial Estate West, Chesterton, Newcastle under Lyme.

PLUNGING PERILS

GDM Partnership Building Services Consultants Ltd were fined £15,000 and ordered to pay £4,230 in costs at Basingstoke Magistrates Court for breaches of Health and Safety law.

The prosecution followed an investigation by the HSE into an incident that occurred on 1st June 2005 at an unoccupied commercial building at Jays Close, Basingstoke. Mr. David Prince was taking measurements of the flat roof when he fell from the edge - a height of approximately 6 metres.

Apart from warning all staff to be careful, GDM took no measures to prevent their employees, including Mr Prince, from falling from the roof. Mr. David Prince from Tunbridge Wells, Kent, suffered fractures to left wrist, left humorous and pelvis.

GDM Partnership Building Services Consultants Ltd from Dartford, Kent, a Building Services and Environmental Engineering practice, was fined £15,000 after being found guilty of breaching Section 2 HSWA. Phill Leonard, HM Inspector of Health and Safety, said: "*This accident could have been prevented if simple precautions had been taken. Falls from height continue to be the biggest workplace killer. Last year 46 people lost their lives following a fall from height and over 3000 workers suffered serious injury.*"

FATAL ELECTROCUTION

Mr Robert Davies, an HGV driver was electrocuted at the Guys Industrial Estate on Tollgate Road in Burscough, Lancashire on 19 August 2005 when a vehicle mounted crane came into contact with overhead electricity cables during the repositioning of portable buildings.

Mr Davies worked alone in the repair and refurbishment of portakabins. A Portakabin that he had sold was being removed from the site by James Walsh on a transporter vehicle fitted with a HIAB crane. The transporter vehicle was being operated by Mr Walsh who had carried out this type of removal before.

The Portakabin had been lifted on to the vehicle by Mr Walsh who was in the process of lowering the crane to its resting position when it came into contact with an overhead high voltage cable. Mr Davies was stowing metal ladders on the vehicle when the crane contacted the cable.

Mr Davies' employer Guy Leasing Ltd of Kensington Road in Souhport pleaded guilty to a charge under Section 2 (1) of HSWA in that it failed to ensure the safety of an employee. They were fined £8,0000. Self employed James Walsh of Aspen Close, Shevington Park in Kirkby pleaded guilty to two charges that he breached Section 3(2) of the Health and Safety at Work Act in that he failed to conduct his undertaking - namely the delivery, removal, repositioning and transport of portable buildings - in such a way as to ensure the safety of people not in his employment - £2,600 fine; and that he breached Regulation 14 of the Electricity at Work Regulations 1989 in that he and Robert Davies were repositioning and removing portable buildings and using a vehicle mounted crane so close to overhead electricity cables that danger might arise - £1,400 fine.

HSE Inspector Michael Clarke, who investigated the incident, said: "*Operators of vehicle mounted cranes must not take chances when required to work near overhead high voltage cables. They must make sure that the cables are not live or where that is not possible take extra precautions to prevent contact with the cables. Furthermore, occupiers of sites with overhead high voltage electricity cables must take appropriate measures to control lifting activities and prevent inadvertent contact with such cables. The tragic death of Mr Davies was avoidable.*"

It is essential that operators of vehicle mounted cranes thoroughly assess the areas in which they carry out lifting activities and identify the presence of overhead high voltage cables. They must observe the safety distances prescribed in relevant standards and guidance and must not take chances near these type of cables.

OWNER OF COCKLER FINED

At a hearing at Ammanford Magistrates' court, Christopher Mossman was fined £10,000 for breaches of a Prohibition Notice issued by the MCA.

In 2005 the intention was announced to open the cockle beds in an area of Carmarthen Bay known as "Three Rivers" for commercial fishing activity. Advice on the safety requirements for vessels operating in this fishery were promulgated prior to the opening on the cockle beds. A few weeks after the beds were opened a decision was made to inspect all vessels operating in the Three Rivers area. All vessels except one were found to be in possession of appropriate and valid certification. The exception was a vessel called the “Confiance”.

On the 2nd September the Confiance was boarded by Officers of the MCA supported by members of Dyfed Powys Police. During this visit a Prohibition Notice was issued which stopped the Confiance from operating commercially until properly certificated. During this visit defects such as no lifebuoys, open and unguarded machinery and pipe work penetrating the boat's hull in poor condition were noted. An open bucket of fuel was also observed. The visit was cut short by the incoming tides as the officers had to make their way back to the shore on foot.

It later became apparent that the Confiance was continuing to work the cockle beds. On four occasions the vessel was observed to be operating by officers from the MCA and South Wales Sea Fisheries Committee. The matter

was handed over to the Enforcement Unit of the MCA for investigation.

During the investigation Mr Mossman failed to respond to any attempt by the MCA Enforcement Unit to discuss this matter.

A decision was made to prosecute Mr Mossman as owner of the Confiance for four breaches of a Prohibition Notice on 12th and 13th September 2005 and 23rd and 24th October 2005 in contravention of the Merchant Shipping Act 1995. Mr Mossman was due to appear at Ammanford Magistrates on 15th January 2007 but failed to attend and the matter was adjourned for a fortnight. He also failed to attend that second hearing. A court warrant was then issued and at the hearing yesterday Mr Mossman pleaded guilty and was fined £10,000 and costs of £250 awarded against him.

The name of the vessel has been changed and is now known as the Darcy Leigh.

In passing sentence the magistrates said "*We consider this matter very serious, the vessel was in significant disrepair, you put lives at significant risk for financial gain*."

Mr Carl Graddage, Area Operation Manager for the MCA in South Wales, stated "*a Prohibition Notice is issued to avoid risk to crew, passenger and the environment. Therefore a decision by an individual to ignore a Prohibition Notice is very serious and cannot be ignored. The fines imposed in this case show how seriously the court viewed this particular matter.”*

FAILURE TO SUPERVISE WORK EXPERIENCE STAFF

Adis Scaffolding Limited of Duckmanton, Chesterfield was fined £10,000 and ordered to pay £3,046 costs at Chesterfield Magistrates Court after pleading guilty at an earlier hearing at these courts on 7 March 2007 to charges brought by HSE.

The case involved a 15 year-old student on work experience who broke his right leg after he got off a forklift truck that was still moving.

Matthew Nash, from Bolsover School, broke his right leg when he got off the forklift truck, which he was traveling on as an unauthorised passenger, at the company's premises on 19 May 2005. The forklift truck was being driven by an unauthorised 16 year-old employee.

Derbyshire HSE Inspector Kevin Wilson said:

"*This incident could have been prevented if the company had provided adequate supervision for the student and the young employee. The employee should not have been able to drive the fork lift truck, as he was not authorised to do so and had not received appropriate training, the student should also not have been able to ride on the truck.*

Young people, especially those new to the workplace or on work experience, will encounter unfamiliar risks from the jobs they're doing and from the working environment. Their lack of experience, absence of awareness of existing or potential risks and lack of maturity mean that they need proper supervision and had this been provided it's unlikely this accident would have taken place. The starting point for employers taking students on work experience is to conduct a young person’s risk assessment. This should identify the controls necessary and the level of supervision required to ensure their health and safety. Work experience students are regarded as employees under health and safety legislation and are protected as such under health and safety law.

ANOTHER FALL FROM HEIGHT

Bradgate Containers Ltd of Leicester Road, Shepshed was fined £5,000, ordered to pay £5,000 compensation and £1,587 costs after pleading guilty to breaching Regulation 4(1)(a) and Regulation 4(1)(c) of the Work at Height Regulations 2005 at Loughborough Magistrates Court 27 March 2007 following a fall from height which caused serious injury.

Welder Richard Brooks, 59, from Shepshed sustained severe head injuries when he landed on the concrete yard surface on 18 September 2006. His fall involved an unsecured aluminium ladder, which was being used as a working place for welding during the building of large shipping containers for housing generators and other equipment packages.

Bradgate Containers Ltd pleaded guilty to a charge of breaching Regulation 4 (1) (a) and (c) of the Work at Height Regulations 2005 of failing to take suitable measures to ensure the work was properly planned and failing to ensure the work was carried out safely.

Roger Amery, HSE Inspector, who prosecuted said: "*These injuries could so easily have been avoided. Health and safety law is not about doing unnecessary stuff; it is about being wise before the event and prioritising risk control effort on the issues that really matter. Falls from height are one of the most common causes of injury and are easily preventable. This is a good firm and an important local manufacturer, but they just didn't have their eye on the ball. The sad consequence was damage to Mr Brooks' brain, a period of great distress for his family and an upsetting time for his workmates at Bradgates; along with harm to this company's reputation. The accident was typical of the type of preventable falls which remain all too common. Had there been a proper plan for this manufacturing work and had good access equipment been in place then this accident would not have happened. An untied aluminium ladder resting on a metal edge is a recipe for disaster. Employers and employees must work together in order to stamp out this sort of thing.*"

UNLICENSED ASBESTOS REMOVAL

North East Environmental Ltd of North Tyneside was engaged last year in the renovation of the former Pipeline Centre at Harvey Combe, Killingworth. The work involved the removal of asbestos for which a licence was required. The company pleaded guilty at North Shields Magistrates Court this afternoon to carrying out the work without a licence between 25 September and 10 October 2006. It was fined £4,600 under the HSWA.

Henry Robinson, a director of the company, of Holmlands, Monkseaton, was also fined £4,600 after he admitted a similar offence. Costs of £4,917.20 were awarded to the HSE, payment to be divided equally between the company and Mr Robinson.

HSE inspector Carol Forster said: "*Companies holding a licence for work with asbestos are required to work to strict standards and systems of work, ensure staff have regular medical checks and work within the conditions of their licence. The Asbestos Licensing regime is not a bureaucratic exercise but an important means of controlling work activities with asbestos which is one of the main causes of occupational disease. This was a case of management failure to ensure that the required licence was held and this serves as a reminder that companies risk prosecution if they don't.*"

ASBESTOS ANALYST FINED FOR INCORRECT CLEARANCE CERTIFICATE AT KNOWSLEY SCHOOL

An asbestos analyst was fined £2,500 and ordered to pay £1,500 costs after pleading guilty to a criminal charge brought by the HSE after he had issued a clearance certificate after removal of asbestos from the boiler room of a school but not all the material had been removed.

Kevin Breithaupt of Hindley Green, Wigan pleaded guilty to a breach of Section 7 of the Health and Safety at Work Act in that he produced a four stage clearance certificate following removal of asbestos, when asbestos was still present in the boiler room of Maryville Primary School in Prescot.

Sarah Wadham, an HSE Inspector who managed the case says: "*The risk to health from asbestos is well known and others may have been put at risk as they worked in the room following the issue of the certificate. Our investigation occurred after HSE received a complaint regarding the standard of the asbestos clean in the boiler room at the school.*

Knowsley Metropolitan Borough Council had organised for asbestos lagging to be removed from the boiler prior to the removal of the boiler room system. Following the asbestos removal Mr Breithaupt produced the certificate which was passed to the council and then onto the contractors who were to remove the boiler. Contractors started to work in the boiler room and became concerned about asbestos material left in the room. Three men - Donald Cowperthwaite, Francis Disley and John Appleton - worked in the room for about three hours until a decision was taken to stop work and query the amount of material left. Lockwoods Technical Services Ltd who were the Principal Contractor for the project commissioned a further asbestos survey and a further clean had to be done. Asbestos related diseases are currently responsible for 3,500 deaths each year and this is the biggest occupational health problem in Britain. The effects of inhalation of asbestos fibres are not usually realised for many years."

FORKLIFT FOLLIES

Tex Industrial Plastics Ltd of Claydon Industrial Park, Great Blakenham, Ipswich, pleaded guilty to contravening the Lifting Operations and Lifting Equipment Regulations 1998 and was fined £3,235 and ordered to pay £1,158.20 costs.

The incident happened on 10 February 2006 when Christopher Bird, aged 36, from Derby suffered substantial injuries including fractures to both legs, pelvis, collar bone and jaw, when a printer being moved on the forks of a lift truck fell on him when the driver reversed up a slope.

HSE Inspector Melvin Sandell said: "*This injury could have been easily avoided if proper planning and supervision had been in place. The forklift truck driver had not previously moved loads with offset centres of gravity and the company had not told him that this was the case with this printer. Whilst this was an unusual lift, the mistakes made were simple and could have been avoided if the employer had planned the job properly and then supervised it. Companies need to be aware that they have responsibilities to ensure that work is carried out by a sufficiently competent member of staff, that it has been properly planned and that work by inexperienced staff is properly supervised. Every year a significant number of people are killed, and even more injured, by accidents involving vehicles in the workplace. Better planning, training and awareness can avoid most of these accidents.*"

MINISTRY OF DEFENCE CENSURED

The HSE censured the Ministry of Defence (MOD) at its London headquarters on 16 March 2007. The MoD had to answer two Crown censures, both arising from fatalities involving the use of workplace transport. HSE's detailed investigations of these incidents brought to light significant systemic shortcomings in the corporate arrangements for assessing transport risks in the MOD. The MOD was censured under Section 2(1) HSWA.

Whilst criminal proceedings cannot not be taken against the Crown, administrative procedures, known as Crown censures, are used in circumstances where it is HSE's opinion that, but for Crown immunity, there would have been sufficient evidence to provide a realistic prospect of conviction in the courts.

The first fatality occurred on 22 May 2003. Corporal Thomas Eirian Rees, 32, died as a result of injuries he sustained when he was crushed between two armoured personnel carriers being unloaded from a low loader at Teesport, Middlesbrough, Cleveland. Cpl Rees was from Pembrey, South Wales.

On 1 May 2004, Lance-Bombardier Robert Wilson, 29, was crushed between a Multiple Launch Rocket System vehicle and a large lift truck at Albemarle Barracks, Northumberland and died from his injuries. L-B Wilson was from Gateshead, Tyne & Wear.

Both soldiers were on duty at the time of these incidents and the activities were subject to the full application of the HSW Act as they took place in Great Britain.

Dr David Snowball, HSE's Director for Yorkshire & North East Region, said: "*The vehicles involved in these incidents are heavy and powerful and Army personnel have to work closely alongside them. The risk of personal injury is therefore potentially high. In bringing these censures, HSE wishes to emphasise to the MOD, and other employers, the importance of assessing, managing and controlling the operational risks arising from the use of workplace transport.*"

BUNCEFIELD INVESTIGATION BOARD PUBLISH

The Buncefield Major Incident Investigation Board (MIIB) has published its 5th report, required by the investigation terms of reference into the Buncefield incident on 11 December 2005.

The report makes recommendations to address improvements in the Design and Operation of sites in the UK that store and transfer petroleum products on a large scale, and responds to the MIIB's term of reference.

The MIIB made clear in the Initial Report published on 13 July 2006, that design and operation of sites was one of its four main areas of concern in this investigation. The other areas of continuing work are emergency preparedness and response to incidents, advice to planning authorities and an examination of the HSE's and the Environment Agency's roles in regulating the activities on the Buncefield site.

On design and operations at storage sites, the paramount need is for precautions to be in place to prevent fuel escaping from the vessels in which it is contained. Further precautions are needed if fuel does escape, to prevent it forming a flammable vapour and stop pollutants contaminating the environment.

Lord Newton, the Chairman of the Buncefield Investigation Board said:

"*This report challenges the industry to substantially strengthen safety standards at sites handling large quantities of fuel. It calls for a programme of revisions to guidance and standards for process safety, environmental protection and excellence in operations. It also calls for a more consistent response to broadly similar major hazard risks than are the case today. Specific recommendations are made for operators to rigorously assess levels of safety and reliability required in the design and operation of relevant sites. The Competent Authority needs to oversee this work and ensure it is done. In preparing this report we have also taken into account the work of others. In particular the Buncefield Standards Task Group has been working on aspects of design and operations, including those recommended in our Initial Report, and we welcome this initiative by the sector and the Competent Authority. Other sources have included industry specialists and experts, and the Baker Report on the Texas City*

City incident in the USA. We also note striking similarities between some of our recommendations and those made last week by the US Chemical Safety Board on the Texas City incident."

Together these areas make up a comprehensive package to reduce risks to those who work on or near such sites, or live nearby, and to the communities and the natural environment that can be damaged by extreme events such as Buncefield.

RAILTRACK FINED £4MILLION

Network Rail, which had admitted health and safety blunders occurred before the crash on 5 October, 1999, was also ordered to pay £225,000 in costs in addition to the £4million fine. A Thames Trains service hit a First Great Western train at Ladbroke Grove, west London, killing 31 people. Critics say the money should come from Network Rail bosses, because otherwise the fines will be paid by the public. As you will no doubt recall Network Rail replaced Railtrack, which had been responsible for maintaining Britain's railways, in 2002. The Thames train had gone through a red light at signal SN109 shortly after leaving Paddington station. Blackfriars Crown Court has previously heard that a "catalogue of failures to act" by Railtrack led to the disaster, which left more than 400 injured.

Prosecutor Philip Mott QC told the court that concerns had been raised about the safety of signal SN109 as early as November 1995. There were seven previous occasions where a driver went through the signal at red - known as Signal Passed at Danger (Spad) incidents - in the five years leading up to the crash. The court heard that Michael Hodder, driver of the Thames train, probably assumed he could continue because of the absence of a visible red at SN109.

Network Rail chairman Ian McAllister said: "*Network Rail is sorry for the failings of Railtrack some seven years ago that contributed to the tragedy at Ladbroke Grove. Network Rail accepts the fine imposed by the court*." Mr McAllister also said that since Network Rail took over from Railtrack it had completed the installation of an automatic train braking system which would have prevented the Ladbroke Grove crash. "*This system, called the Train Protection Warning System (TPWS), will automatically apply a train's brakes if it passes a signal at red or approaches one too quickly*," he said.

Maureen Kavanagh, chairman of the Safe Trains Action Group, lost her son Peter, 29, in the 1997 Southall rail crash. She said: "*A fine is not enough and is not justice. It's taxpayers' money anyway. The money will just be shuffled around from one government department to another.*"

Keith Norman, general secretary of the drivers' union Aslef, said the money should be taken from the bonuses of senior Network Rail managers. "*If the managers are not fined personally, it means the fines will be paid by the public*," he said. "*The fine imposed will come out of company funds and be paid to the government - which effectively owns the company. So the only people to suffer from the fine will be the travelling public because the fine will mean that the company has less to spend on the rail infrastructure of this country*."

Rail Maritime and Transport union general secretary Bob Crow said: "*Privatisation, fragmentation, the absence of train protection and the lack of corporate accountability were at the heart of the Ladbroke Grove tragedy, and each problem remained to be dealt with*."

Chris Newell, the Crown Prosecution Service's principal legal adviser, said British Transport Police had conducted "exhaustive inquiries" into the crash and produced "thousands of pages of evidence." He said: "*The evidence led to the inescapable conclusion that Network Rail failed utterly in its responsibility to protect the health and safety of passengers in its care.*"

"WHICH MASK DO YOU PREFER?" HSE ASKS CAR PAINT SPRAYERS

Wearing a safety mask or an oxygen mask was the stark alternative put to Cumbrian vehicle paint sprayers at a Health and Safety Executive safety day in Penrith on 28 March.

More than 80 Cumbrian and north Lancashire firms attended two sell out half day events at Rheged were they were told that vehicle paint sprayers are 80 times more likely to get occupational asthma than the average worker (the worst industry sector) and six or seven times more likely to get occupational dermatitis (in the top ten sectors). Paint spray created during work cannot be seen, tasted or smelled and takes time to clear from a spray booth - with times as variable as two and 20 minutes.

HSE advises that to assess when it is safe to go into paint spray rooms, MVR maintenance companies use smoke to replicate the paint mist that clears in similar times.

The free Safety and Health Awareness Day (SHAD) for MVR paint sprayers showed: -

* How asthma can rob you of your health and livelihood;

* How to stay healthy and save money;

* How to get spray booths right first time and keep it that way;

* How and why respirators fail and how to tell if you're at risk

* How to save your skin from dermatitis by avoiding rash decisions

HSE inspector Mark Piney said: "*Virtually all body shops use isocyanates paints which cause asthma in anyone using them. Paint sprayers are most at risk and many are forced to give up the work. But the risk can be controlled - there's no need to get sick or lose your livelihood. Use of properly fixed and adjusted respirators will prevent breathing in of paint mist that can cause occupational asthma. Motor Vehicle Repair (MVR) and associated industries cover activities such as the maintenance and repair (including tyre, exhaust, windscreen etc replacement); body repair, refinishing and valeting; MOT testing; and the roadside recovery of motor vehicles.*

Whilst most of these activities are carried out at MVR garages and 'Fast fit' centres, they are also undertaken at customers' premises, both commercial and domestic, and at the roadside. The boundaries between the different types of outlet is becoming more and more blurred as enterprises take on a wider range of activities in an increasingly competitive market.

The Rheged event was the last road show in a three year HSE advice and inspection campaign.

Latest available figures estimate that the MVR industry in the UK employed just over 170,000 people in about 44,000 businesses. The statistics also show that the industry is still dominated by small and medium-sized businesses (SMEs) with over half the workforce (~58%) employed in either zero-employee enterprises e.g. sole traders or partnerships, or businesses employing less than 10 people. Companies with less than 50 people accounted for approx. 83% of the workforce.

The industry has fatal and 'all injuries' accident rates higher than the average for the whole of manufacturing. Over the three years from 2001 to 2003, nearly 5,500 injuries were reported to the HSE and Local Authorities (LAs) from businesses where the main activity was MVR.

During the same period there were 16 fatal injuries to employees or self-employed persons and almost 1,200 other major/serious injuries, some involving members of the public. The actual figures for serious and less serious injuries will be much higher than those quoted due to considerable under reporting to the enforcing authorities.

FARM SAFETY

More than 200 farmers from across Cambridgeshire were invited to attend a farm safety day, run by the Health and Safety Executive (HSE) at The East of England Showground in Peterborough yesterday, Tuesday, 27 March.

The event was organised in an effort to reduce the number of farm workers killed and injured each year. The Health and Safety Executive has employed a number of approaches to try and help make the industry safer, including traditional inspections of individual farms. However, smaller family businesses do not all find this approach helpful, often prefering practical advice delivered by people from the industry without feeling there is a threat of enforcement hanging over them. Self-employed family farmers from across Cambridgeshire, who may have had little contact with the HSE in recent years, were therefore invited to attend.

HSE Inspector David Head said: "*Every year too many people, including children, are killed in horrendous accidents on farms. Many of these tragedies could be prevented by adopting sensible management of risks - the people best placed to do that are farmers and their staff working together to improve health and safety in this critical area.*"

The safety day featured scenarios covering issues causing the majority of injuries and ill health including farm transportation, safe working at height, safe use of ladders, farm machinery maintenance and manual handling. Each scenario highlighted the risks involved and there were practical demonstrations on how these risks can be eliminated or reduced to acceptable levels. Mr Head added:

"*Agriculture continues to be the most hazardous industry to work in, with a fatal injury rate that is higher than any other industrial sector. On average over the last ten years almost one person a week has been killed as a direct result of agricultural work. But, whereas the number of fatal accidents to employees is decreasing, that for the self-employed is going up, with almost three times more self-employed workers than employees killed last year. HSE is particularly concerned with child safety as half the fatal accidents to members of the public on farms, between 1993 and 2003, were to children.*"

SENSE AND SENSIBILITY?

In a speech at the Institute of Occupational Safety and Health (IOSH) conference, at the International Centre, Telford on 28 March, Geoffrey Podger explained how the world of work had changed since the Health and Safety at Work Act was first introduced in 1974. He stated: "*If we are going to ensure the world of work is as safe and as sustainable as possible, then we need to be flexible enough to respond effectively to the challenges as they arise.*" Mr Podger reiterated that a flexible and resolute approach will be required to response to constantly changing work environments and make them as safe, healthy and sustainable in the future.

A key aspect of his speech was to outline the new ways that HSE are working in response to these changing times, "*Partnership is one of our key strategic themes. We cannot be responsible for improving the nation's occupational health and safety on our own.* " HSE is working very closely with local authorities, and other organizations such as the Institute of Directors (IoD) to achieve mutual objectives. Through a new authoritative guidance on directors' responsibilities for health and safety, HSE with the IoD is reaching out to boards and directors to secure their commitment to ensure successful health and safety performance.

Mr Podger also urged sensible risk management, saying that the principle of health and safety was to ensure the good health of all, and not to stop people living normal lives. Sensible risk management is about taking practical steps that benefit all. The HSE has seen much progress since the year 2000. The average days lost per worker due to work related ill health and injury has dropped from 1.8 to 1.3. However, he stressed there was no room for complacency - there were still 28 million working days lost each year due to ill health, while occupational ill health costs the UK economy over £11 billion each year.

Setting out a clear challenge for employers Mr Podger concluded, "Health and safety will always be a 'Forth Bridge' problem: as soon as restoration is finished, the need is to start again.

WORKER INVOLVEMENT IS VITAL

Delivering the annual lecture in memory of Sir Pat Lowry, the former Acas Chairman, Bill Callaghan, Chair of the Health and Safety Commission, stressed the vital link between good health and safety and active employee involvement and set out the challenges that have to be met to prevent harm to workers and to promote health and well being in the workplace.

Bill Callaghan paid tribute to the ground breaking work of the Robens Committee's work leading to the enactment of the Health and Safety at Work etc Act in 1974. Robens, who recognised that the new statutory arrangements should be designed to provide a framework for better self-regulation, wrote "*Safety and health at work is a matter of efficient management. But it is not a management prerogative. Workpeople must be encouraged to participate fully.*"

Citing the success of the close collaboration between Acas and HSE on stress management Bill Callaghan called on other stakeholders to follow this lead, "*Health and safety needs to re-discover its roots, re-discover the art of the possible, rather than pursue the ideal of the perfect. The human relations and health and safety communities need to work more closely together to achieve this goal*."

Bill Callaghan praised the partnerships between trade unions and employer and trade organisations in industries such as construction, paper and board and quarrying. Innovative approaches had been put in place by employers and trade unions which had resulted in the building of constructive and fruitful partnerships, genuine worker involvement and consultation, the reduction in disputes and the achievement of exemplary standards of health and safety. But these arrangements were not as numerous as they might be.

Bill Callaghan added that employers and unions might both have missed opportunities, "*It must be to the benefit of both the regulator and the regulated that we spend less of our scarce resources on the relatively good performers and more on the poor performers. But in this country, unions have viewed initiatives such as the US Voluntary Protection Programme with suspicion. And on the other side of the table some employers may well be suspicious of giving trade union or other employee representatives more of a role, for example a quality assurance check on the company's safety performance and procedures.*"

Bill Callaghan also emphasised the need for genuine involvement and consultation rather than rigid structures. The aim should be to achieve progress by mutual consent.

Bill Callaghan went on to say, "*My view is that informal regulation via unions and employers will be more efficient and less onerous than regulation imposed externally, either by HSE or through the courts*." "*Joined up inspection*", he said, "*had a considerable role to play too if we are to achieve our health and safety goals and the case for joining up the different labour market inspection regimes had considerable attraction. Not every health and safety problem needs a new law. We also need to work closely with our partners to join up and make readily accessible the wealth of advice, guidance and best practice that already exists. Self-regulation and worker involvement are inextricably linked*."

Bill Callaghan concluded: "*We have come a long way since the early 19th century, though we cannot take the safety improvements made for granted. Inspectorates need to work more closely together, as do employers and employee representatives, not just to prevent harm but to promote well being, good jobs and a high performing and competitive workplace. Now there is a challenge for us all. And we meet that challenge through partnership*."

Ed—The Lowry Lecture is held annually in honour of Sir Pat Lowry. Sir Pat was a former chair of Acas, a Visiting Professor at the University of Warwick, a member of the Warwick Business School Advisory Board and close associate of the Industrial Relations Research Unit

"WE ARE ABOUT SAVING LIVES, NOT STOPPING LIVING"

Don't wrap children up in cotton wool – we are here to save lives, not stop living! That's the message from Jonathan Rees, Deputy Chief Executive of the HSE, speaking to childcare professionals at The Barnardo's Annual Conference: Childhood Matters in London on 20 March 2007.

Mr Rees explained the importance of risk and adventure in children's lives and recognising the need to manage it. On closer investigation, many of the concerns we read about are based on myths. Conversely, when something goes tragically wrong, there is often a media and public outcry that "something must be done!" It is vitally important to get a balance between the two extremes.

Jonathan Rees said, "*Everyday a vast number of activities go ahead without a hitch. If we were to stop play and adventure activities we would deny children their right to learn, develop and have fun. And any gain in safety would be far outweighed by increasing rates of obesity and related disease. HSE has consistently called for adventure and activities to continue – with the risks being responsibly managed. It is worth pointing out that many of the concerns we read about health and safety are based on myths. For instance: HSE does not expect risk assessments for everyday low risk activities like playing conkers and contrary to popular belief - teachers are not personally sued for damages - we cannot find a singe example of an individual teacher being sued in the past 5 years.*"

"*The Health and Safety Executive is keen to stimulate a broader debate in this area. The HSE's 10 sensible risk principles were launched in August last year and further work has been done with DFES on its "Learning outside the classroom" manifesto. Simple, practical advice is available on how to do risk assessments, encouraging everyone to think carefully about the right risks and not write at length about the trivial ones. The HSE has consistently sought to learn from tragic accidents and to disseminate lessons. We will prosecute on those very rare occasions when there is flagrant disregard for sensible precautions.*"

The message to children, parents, carers and teachers is that we want to save lives not stop living. Risk will not ruin childhood; but ill-managed and over protective actions could do so.

Sensible risk management IS about:

• Ensuring that workers and the public are properly protected;

• Providing overall benefit to society by balancing benefits and risks, with a focus on reducing real risks – both those which arise more often and those with serious consequences;

• Enabling innovation and learning, not stifling them;

• Ensuring that those who create risks manage them responsibly and understand that failure to manage real risks responsibly is likely to lead to robust action; and

• Enabling individuals to understand that as well as the right to protection, they also have to exercise responsibility.

Sensible risk management IS NOT about:

• Creating a totally risk free society;

• Generating useless paperwork mountains;

• Scaring people by exaggerating or publicising trivial risks;

• Stopping important recreational and learning activities for individuals where the risks are managed; and

• Reducing protection of people from risks that cause real harm and suffering

MINISTER ANNOUNCES NEW DOMESTIC GAS SAFETY DRIVE

Health and Safety Minister Lord McKenzie announced a new scheme to improve domestic gas safety. This follows a review which found unacceptably low public awareness about the risks of carbon monoxide poisoning from gas appliances.

The new regime will be overseen by the HSE and delivered by industry via a reformed gas installer registration scheme. A single provider will be appointed to run this new scheme, which will be responsible for driving and coordinating industry action to raise public awareness of gas safety; provide new incentives to registration (such as simplifying the registration process); and possibly have new limited enforcement work.

There will be a strict framework, setting out performance and requirement criteria, to allow strong oversight of the new scheme by the HSE.

Lord McKenzie said:

"*Complacency on gas safety is not an option. New research suggests that nearly half of all households using gas had received no information about the dangers it can pose. While the number of gas related fatalities has reduced over recent years, tragic incidents still occur. The new scheme is designed to ensure industry works together to raise public awareness and so further reduce deaths and incidents caused by ignorance of gas safety risks and especially CO poisoning*."

Bill Callaghan, Chair of the Health and Safety Commission said:

"*HSC/E's aim has been to look for ways of making a good record on gas safety even better for gas consumers. In our "Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond" we said there were things that would need to be done differently, with others getting involved. The new gas safety regime announced today by Lord McKenzie, on advice from the Commission, will do just that by reducing bureaucracy, seeking to simplify the law, strengthening industry participation and securing the best use of resources. The changes we are making are about delivering improved gas safety for millions of gas consumers. I look to all the stakeholders involved to work together to that end*".

The new regime follows extensive stakeholder consultation. Competitive bids will be invited to operate the new scheme for a five year period. The new provider will be appointed by the HSE, on advice from a panel with independent representation. Performance and efficiency will be monitored by the HSE throughout the duration of the appointment.

Ed - There were 16 fatal gas related carbon monoxide poisoinings in 2005/06, which is half the number there was ten years ago. Reported non-fatal incidents in the same period are broadly static at around 200 per year.

MINISTER ANNOUNCES DOMESTIC GAS SAFETY DRIVE

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