

# BRUNSWICKS' REGULATORY NEWS

## IN THE COURTS AND THE PUBLIC EYE

### ALL RESPONSIBLE FOR WORK ON FRAGILE ROOFS

*"Everybody involved in planning and carrying out construction work has some responsibility for ensuring the health and safety of the workers. This case brings home the possible tragic consequences if they fail to do carry out their duties."* HSE Deputy Chief Executive Justin McCracken said after the court imposed fines totaling £68,000.

Darren Brownbill a scaffolder from Warrington died after falling through a fragile roof light while working on an extension to the warehouse operated by Unichem PLC on Walton Summit, Preston on 9 June 2003.

Three companies and two individuals have been fined a total of £68,000 and ordered to pay £40,407 costs at Preston Crown Court after being prosecuted by HSE.

Ian Connor, Acting Principal Inspector for the HSE, said: *"This was a tragic incident in which a man lost his life in circumstances that could so easily have been prevented. The dangers presented by fragile roof materials have been well known for many years, yet were not taken into consideration in this case. Considerable time had been spent planning the job and any one of those involved had the opportunity to realise that somebody could fall through the warehouse roof. Simple steps could then have been taken to prevent this death. If this had been done, Darren would still be alive today."*

The following were charged:

Darren's employer Telford Tower & Scaffolding Ltd of Castle Trading Estate, Priorslee, Telford, Shropshire pleaded guilty to a charge under Section 2(1)HSWA.

The company was fined £35,000 and ordered to pay £20,000 costs

- Pochin (Contractors) Ltd of Brooks Lane, Middlewich, Cheshire the main contractors for the work, pleaded guilty to a charge under Section 3(1) of the HSW Act. The company was fined £25,000 and ordered to pay £15,000 costs
- Unichem plc of Unichem House, Cox Lane, Chessington, Surrey, the clients for the work, pleaded guilty of a charge under the Regulation 11 of the Construction (Design and Management) Regulations 1994 (CDM Regulations). The company was fined £3,000 and ordered to pay £2,407 costs
- David Isherwood, a partner in the firm of Isherwood McCann of Rose Park, Lutterworth Road, Blaby, Leicester, the project designer, pleaded guilty to a charge under Regulation 13 (2) (a) (i) of the CDM Regulations. He was fined £2,500 and ordered to pay £1,500 costs
- Ian McCann, a partner in the firm of Isherwood McCann of Rose Park, Lutterworth Road, Blaby, Leicester, the planning supervisor for the project, pleaded guilty to a charge under Regulation 15 (1) of the CDM Regulations. He was fined £2,500 and ordered to pay £1,500 costs.

Ed—It often comes a shock, particularly to a client in a construction or maintenance situation that the retention of specialist contractors is not sufficient to relieve them of their health and safety obligations. That said one cannot but have sympathy for those injured or killed and their dependents as well as a client who believes he has done the right thing by calling in the experts and then finding their failure to plan highlights his failure to consider what he could do to minimise the health and safety risks as the law requires.

## DEATH AT WORK

Dawson Wam Ltd of Westoning Road, Greenfield, Bedfordshire was fined £75,000 and ordered to pay costs of £34,425 at Chester Crown Court after pleading guilty to a charge under the HSWA that they failed to ensure the health and safety of their employees.

The court heard that piling rig operator 63 year-old Peter Roberts died on 10 May 2004, four days after an incident on the site of the Quinn Glass bottle manufacturing facility at Elton, Chester.

Dawson Wam Ltd was constructing 7,500 piles as part of the foundations. The process involved drilling a hole into the ground with the auger of a piling rig, pumping concrete into the hole as the auger was withdrawn and finally inserting reinforcement bars.

On the day of the accident there was a delay in the delivery of concrete to Mr Robert's piling rig and concrete which remained in the flexible rubber hose used to connect a concrete pump to the rig began to harden, leading to a blockage.

After attempts to clear the blockage failed, it was decided to try using compressed air. The flexible hose was broken up into individual sections and at least two of these were blown out with compressed air without their ends being restrained. During the unblocking of the last section, the end of the hose whipped upwards and struck Mr Roberts on the head, causing fatal injuries.

HSE prosecuted the company, alleging that they had failed to ensure the provision and maintenance of systems of work which were safe and without risk to employees during the cleaning and unblocking of the piling rig and associated equipment

HSE argued that despite the company being aware that this was a high risk operation, they had failed to carry out a formal risk assessment of the cleaning and unblocking of the rig, which meant there was no safe system of working.

HSE inspector Robert Hodgkinson said:

*"This was a tragic accident which resulted in the death of a man approaching his retirement. Mr Roberts was highly thought of by his family, friends and colleagues. It has affected all those who knew him very badly. Cleaning out or unblocking piling rigs and associated equipment, such as concrete pumps and pipe work, with compressed air is a very high risk activity and should therefore have been formally assessed.*

*A risk assessment is the starting point for developing a formal safe system of work for such operations. Once developed, clear instruction and training should then be given to those carrying out the work. Whilst no charges were brought directly in relation to selecting compressed air as a method for this particular operation, a safer alternative to clean out such equipment would be to use water. Indeed, the British Concrete Pumping Group Code of Practice states that using compressed air to clean out a pipeline should only be done when there is no practical alternative.*

*The operation must be carried out under the close supervision of a suitably trained person. I recommend that all piling companies and others who use concrete pumps and associated equipment reassess their cleaning and unblocking operations to ensure that they have safe systems of work in place, and that employees carrying out such activities have received clear instruction and training".*

## COMPLY WITH IMPROVEMENT NOTICES

Dunelm Property Services Ltd (DPSL) was prosecuted by the HSE for failure to comply with the requirements of Improvement Notices relating to conditions on a housing construction site at Lakeside Gardens, Barmston, Washington, where the company were acting as principal contractor, in February and March 2006. They were fined a total of £44,000.

After the case, Acting Principal Inspector Rob Hirst said: "*Failure to comply with statutory requirements is a serious matter and failing to address the requirements of an Improvement Notice is very serious indeed. HSE will take appropriate enforcement action in such cases*".

At Sunderland Magistrates' Court DPSL, of Esh House, Bowburn North Industrial Estate, Bowburn, County Durham was fined £14,000 for each of three offences under HSWA 1974 relating to a failure to comply with an Improvement Notice on good order; a failure to comply with an Improvement Notice on segregation of pedestrians and vehicles on site; and a failure to ensure the safety of employees.

In addition, the company was fined a total of £2,000 for two offences under the Construction (Health, Safety and Welfare Regulations) 1996 relating to good order on construction sites; and lack of segregation between pedestrians and vehicles on site. It admitted all the offences.

It was also ordered to pay £1,784 costs.

HSE Inspector Jonathan Wills said: "*On 27 February 2006 two Inspectors visited the site and, as a result of the conditions they found, issued two Improvement Notices. These related to the company's failure to both organise the site in such a way that pedestrians and vehicles could move safely and to ensure that every part of the site was kept in good order. When Inspectors returned to the site on 27 March 2006 to check that the Improvement Notices had been complied with, the conditions found showed no improvement to those observed on 27 February. In short, DPSL failed to comply with the requirements of the Notices*".

Mr Wills added: "*Construction is Britain's biggest industry with approximately 2.2 million people working in it. It is traditionally seen as one of the most dangerous. In the last 25 years over 2,800 people have died from injuries received as a result of construction work, including 572 construction workers killed at work in the past ten years. Traffic management on construction sites is one of our priorities. Being hit by a moving vehicle accounted for eight deaths - 14 per cent of a total of 59 - in the year 2005/06. Principal contractors should have a traffic management plan in place, keep vehicles and pedestrians apart, ensure vehicles are properly maintained, use competent drivers and select the most appropriate vehicle for the task.*"

## AND THERE'S MORE

William Beach, a director of Techlink Enterprises Ltd, an office furniture manufacturer, of Abbey Lane Industrial Estate, Burscough was charged with offences related to failing to comply with two Improvement Notices. Ormskirk Magistrates' Court fined him £2,000 and ordered him to pay £1,000 costs.

Following a visit on 29 March 2006, the HSE issued two Improvement Notices which required a thorough examination of the ventilation system provided for the control of wood dust and the provision of a handrail to prevent anyone falling from the open edge of a higher floor level. The HSE inspector revisited the premises on the 26 June 2006 and found that the Enforcement notices had not been complied with.

HSE Inspector Lisa Bailey said: "*The Improvement Notices offered the opportunity to carry out the work that needed to be done to ensure that employees didn't suffer ill health because of the wood dust in the air and that a hand rail was fitted to the mezzanine level. When HSE returned the work had not been carried out and this prosecution has resulted. Improvement Notices are only issued where action needs to be taken for the safety and protection of employees. In this case a company director did not ensure the work was carried out when the Improvement Notices were issued, leaving the health and safety of staff at risk.*"

William Beach pleaded guilty of two charges under section 37(1)(1) Health and Safety at Work etc Act 1974, of allowing offences to be committed by the company of failing to comply with the requirements of Improvement Notices.

## ACCIDENT PRONE NURSES?

The Director of the HSE in Scotland, Stewart Campbell, has highlighted to nurses the importance of working together to reduce accidents and ill health.

Whilst there is a downward trend in recent years in the incidence of ill health and accidents resulting in workers taking three or more days off work, the latest figures (2005/06) show 160,000 people suffered from an illness which they believe was caused or made worse by their current or past work, and 9,556 employees suffered over three day injuries in Scotland.

Speaking at the Royal College of Nursing (RCN) Occupational Nurse Forum Scotland, Mr Campbell welcomed the trend, but stressed the need to work together to maintain the downward momentum. He outlined the importance of links between a range of organisations bringing together HSE, local authorities, employers and employees to reduce incidence rates.

Mr Campbell outlined the work of the Partnership on Health and Safety in Scotland which brings together all the main stakeholders in the country to identify and consider how improvements to health and safety in Scotland can most effectively be delivered.

He also emphasised the importance of organisations taking a management approach to health at work which enabled problems to be dealt with at source and managed positively to keep people in work. He said it was important in the workplace to stand back and take a broader view of the issues affecting health and safety, and to integrate the various factors involved when resolving a specific problem. The same was true when looking at problems which could arise both at work and from domestic and leisure activities, such as bad backs.

Stewart Campbell said:

*"You as individuals, together with your managers and colleagues have a crucial and joint role to play in reducing workplace health and safety problems. Every organisation should have effective systems in place to monitor and improve health and safety. Organisations can benefit hugely from a better understanding of how different health and safety issues are interlinked and how their solution needs a joined up approach."*

The RCN Conference, entitled 'Making the Right Connections' brought together hundreds of nurses to look at occupational health and provide an opportunity for them to engage with colleagues in the profession and share ideas on practice, management, education, and research in the field.

## DIVE BOAT OWNER PROSECUTED

On 13th August 2005, the dive boat Sovereign II owned by Sovereign Diving Limited and skippered by Christopher Wilson sailed on a diving trip from Seahouses to the Farne Islands with a party of nine divers. The trip turned to tragedy when one of the divers Michael Ward of Loughborough in Leicestershire, was struck by the propellers as he was returning to the boat. He lost his left leg and suffered such severe injury to his right leg that it has been pinned and cannot be flexed. The quick reactions of his dive buddy and nearby charter boat called Moby, ensured that Mr Ward was taken back to port quickly where a doctor and nurses who were passing by gave help. A trauma surgeon, who was diving nearby, also sped back to Seahouses where he took charge of the medical team and accompanied Mr Ward to Newcastle General Hospital.

Investigations by the Maritime and Coastguard Agency revealed that the skipper Christopher Wilson did not hold the necessary certificate of competence to be in charge of the boat. Mr Wilson was employed by Sovereign Diving Ltd as crew on their passenger boat Sovereign IV. However when the skipper of Sovereign II left in early July, Wilson was made skipper. He had been sailing as skipper without a certificate of competence for five or six weeks before the incident date.

In Newcastle Crown Court on Monday 16th April 2007, Mr Toby Douglas, a director of Sovereign Diving Ltd., and Christopher Wilson, the skipper of Sovereign II, pleaded guilty to a breach of the Code of Practice for Small Commercial Vessels, also known as the "yellow code".

Sovereign Diving was fined £5,000 and ordered to pay £3,500 towards costs, and Christopher Wilson was fined £500 and was ordered to pay £500 towards costs.

Captain Allan Marsh, Enforcement Officer stated *"This was a very tragic incident. Owners and Skippers of dive vessels are reminded that they are responsible for ensuring full compliance with the Code of Practice and that their vessels are operated in a safe manner. When involved in diving operations, the MCA recommends that propeller guards are fitted. In this case, the Sovereign II was a single handed operation. The owner/managing agent should ensure that there are sufficient additional crew on board having regard to the type and duration of voyage being undertaken."*

In passing sentence on Tuesday 24th April 2007, His Honour, Judge John Evans said

*"This case demonstrates all too unhappily two things. Firstly, that underwater diving, whether it be commercial or pleasure based, is a potentially hazardous activity. Secondly, it demonstrates that there is a need to carefully regulate the way that those who are involved with it either as a sport or a business go about it; that includes not just the divers themselves, but equally important the support crew. The dangers in this case graphically demonstrate the dangers of this activity. What happens off the Blue Cap Rocks on the 13th August 2005, and the outcome for Mr Ward which left him with severe injuries should serve as a constant reminder in the future of these principles."*

## TWO FALLS FROM HEIGHT

Gary Gray an employee was working at the Sun Gardens development in Sun Street, Thornaby-on-Tees, on September 29, 2005, when he fell approximately 5m down an open stairwell while ascending an unsecured ladder. He suffered injuries consisting of a fractured frontal bone, a broken nose and multiple fractures to his left wrist.

HSE Inspector Victoria Wise said: *"Work at height is still the single biggest killer in the construction industry. In 2005/06 there were 24 deaths due to falls from height and many more workers were seriously injured. This incident demonstrates the importance of employers ensuring that work at height is properly planned and that there are safe systems of work in place that can be implemented. Systems for safe work at height should not be left to the employees on site to devise."*

Robertson Homes Ltd, of Perimeter Road, Pinefield, Elgin, Morayshire, were prosecuted by the HSE and admitted three offences under health and safety legislation. One offence related to failing to ensure the safety at work of all their employees and the other two to failure to comply with the Work at Height Regulations 2005. They were fined a total of £2,500 and ordered to pay £2,889 costs.

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Steven Davieson of Nelson suffered severe upper body damage after a fall through a fragile roof.

Fishers Electrical Mechanical Ltd of Bammers Lane End, Bolton by Bowland near Clitheroe, Lancashire pleaded guilty to a breach of Regulation 7(1) of the Construction (Health, Safety and Welfare) Regulations 1996 at Hyndburn Magistrates' Court following a HSE prosecution. They were fined £2,500 and ordered to pay cost of £2,278.80

HSE Inspector Ian Connor says: *"Mr Davieson, of Nelson, fell approximately six metres through a fragile roof while undertaking the stripping and re-roofing of an asbestos cement sheeted barn on 12 October 2004 at Higher Wenshead Farm in Darwen. He suffered severe bruising to his body, lung damage and damage to the nerves in his chest wall. He has suffered mobility problems over a continuing period of time and continues to receive medical treatment. The case graphically illustrates why, when planning their work, companies should ensure that they make appropriate assessment of jobs and then take suitable precautions so that staff are prevented from walking on such fragile surfaces. Mr Davieson's case is sad enough, but falls through roofs often lead to fatalities with huge cost, both in financial terms for companies and in emotional terms for the families of the deceased."*

## ANOTHER FAULTY BOILER INSTALLATION

Check your gas workers are accredited by CORGI before allowing them to carry out gas fitting or repair work.

This warning from the HSE comes after a Barrow heating company was fined £2,000 and ordered to pay £2,732.00 costs after pleading guilty at Barrow Magistrates Court to two criminal charges brought by HSE over the faulty installation of a boiler at a property in Barrow by an employee who was not registered with CORGI.

Andrew John Major was a director and employee of Lakeland Underfloor Heating Specialists Limited of Brow Avenue, Newbarns in Barrow and was involved in installing a Wolf combi boiler in the loft at Bank House Farm at Broadgate in Hallthwaites. Following a dispute with the property owner about Mr Major's CORGI registration, another registered firm discovered a leak where a pipe connected to the boiler and other installation faults.

The company pleaded guilty to two charges of two charges:

- that they had breached Regulation 3(3) of the Gas Safety (Installation and Use) Regulations 1998 by allowing a person not a member of a class of persons approved for the time being by HSE to carry out installation work on the boiler;
- and that work on the boiler was not carried out in accordance with appropriate standards and in such a way as to prevent danger to any person, in contravention of Regulation 5(3).

HSE Inspector Clint Backhouse said: *"Gas appliances that are faulty or poorly installed can lead to death from carbon monoxide poisoning and fire or explosion. That is why the law requires those working on them to be fully trained and registered with CORGI. Fortunately there were no injuries or fatalities in this case, but the potential for disaster was there. It was first discovered there was a problem with the boiler installation because the engineer brought in by the property owner detected a strong smell of gas when entering the loft at the outset. It was very fortunate that the leaked gas had not found a source of ignition by then. This occurrence has shown, fortunately without serious consequences, how important it is for anyone carrying out work on gas systems to possess the necessary expertise, something that the statutory registration scheme run by CORGI is there to ensure."*

## GUILLOTINED

Agrilek Ltd of Duke Street, Barrow in Furness were fined £2,500 and ordered to pay £1,811.65 costs at Barrow Magistrates Court after pleading guilty to a breach of Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998 following an incident on the 9 August 2006. 49 year old worker Douglas Moore lost the tip of his index finger when he was using a guillotine

HSE Inspector Mhairi Duffy said:

*"Mr Moore lost the tip of his finger in the guillotine because his employers failed to prevent access to the dangerous parts of the machine. The consequences of this incident could have been far worse. This case graphically illustrates that companies should ensure all their machinery is properly guarded for the safety of all employees."*

Ed—PUWER 1998 Regulation 11(1) states that,

Every employer shall ensure that measures are taken in accordance with paragraph (2) which are effective-

- (a) to prevent access to any dangerous part of machinery or to any rotating stock-bar; or
- (b) to stop the movement of any dangerous part of machinery or rotating stock-bar before any part of a person enters a danger zone

This could have been prosecuted under s2 HSWA as an alternative. One wonders whether there was a suitable and sufficient risk assessment in addition.

## ASBESTOS RISKS AND THE STATE

The HSE has warned local authorities, schools and contractors about the dangers of disturbing asbestos, and their responsibility to ensure correct procedures are in place to manage asbestos in schools. The warning follows a prosecution brought by HSE against two firms and a company director who were sentenced at Northampton Crown Court.

In summer 2003, asbestos ceiling tiles at Southfield School, Kettering, were removed as part of work to upgrade the school's electrical system. During the works, asbestos was released into the air posing a danger to workers and cleaners at the school. Pupils were not at risk as the work was undertaken during the summer holidays but they were unable to return to school until the following Easter.

Briggs and Forrester (Electrical) Ltd of Northampton were fined £60,000 and ordered to pay costs of £30,000 after pleading guilty to the following charges at Northampton Crown court:

between 28 July and 22 August 2003, they failed to ensure, so far as reasonably practicable, the health of employees working at Southfield School for Girls, Kettering, who were exposed to asbestos while installing electrical equipment, thereby contravening the duty imposed by Section 2(1) HSWA;

They failed to ensure, so far as reasonably practicable, the health of persons not in their employment who were exposed to asbestos while electrical equipment installation was being undertaken, thereby contravening the duty imposed by Section 3(1) of the HSWA.

B & W Asbestos Removal Specialists Ltd of Bedford were fined £30,000 and ordered to pay costs of £10,000 after pleading guilty to the following charges:

between 28 July and 22 August 2003, they failed to ensure, so far as reasonably practicable, the health of employees working at Southfield School for Girls, Kettering, who were exposed to asbestos whilst removing ceiling tiles, contravening the duty imposed by Section 2(1) of the HSW Act;

between 28 July and 22 August 2003, they failed to ensure, so far as reasonably practicable, the health of persons who were not their employees as a result of work at Southfield School for Girls, Kettering, contravening Section 2 (1) of the HSW Act;

- between 1 July and 22 August 2003 they contravened Regulation 3(1) of the Asbestos (Licensing) Regulations 1983 by failing to notify the work; and
- between 30 May and 22 August 2003 they contravened Regulation 6 (1) of the Control of Asbestos at Work Regulations 2002 by failing to plan the work.
- Mr Marcus Buckle, Managing Director of B & W Asbestos Removal Specialists Ltd, was fined £10,000 and ordered to pay costs of £5,000 after pleading guilty to the following charges:
- between 1 July and 22 August 2003 the contravention of Regulation 3(1) of the Asbestos (Licensing) Regulations 1983 was committed with his consent or connivance or was attributable to his neglect; and
- between 30 May and 22 August 2003 the contravention Regulation 6 (1) of the CAWR 2002 was committed with his consent or connivance or was attributable to his neglect.

Richard Lockwood, HSE Principal Inspector, said, "*Asbestos can be a killer if disturbed, but if contained and well managed poses minimal health risk. More than half a million non-domestic premises still contain some form of asbestos, posing a real threat to maintenance workers. They could easily drill or cut into the material, causing exposure to deadly fibres. If anyone is in any doubt about their responsibilities under either the HSW Act or the revised Control of Asbestos at Work Regulations, which came into force last November, they must ask. HSE has a wealth of information on its website and also a public telephone enquiry service.*"

Southfield School was closed for six months whilst decontamination works were carried out. As part of this process, the school lost coursework, teachers' notes and all their computer equipment due to potential contamination. The school was stripped out and refitted at a cost of £6.5 million.

## NEW CDM REGULATIONS IN FORCE

Following extensive consultation with the construction industry, the new Construction (Design and Management) Regulations 2007 (CDM 2007) come in to force on Friday 6 April 2007. Making it easier for duty holders to comply with the requirements, they simplify and clarify existing Regulations.

Through a focus on managing risks on site, reducing paper work, encouraging team work and getting the right people for the right job at the right time, the implementation of these Regulations are expected to see a step change improvement in health and safety performance within the industry.

Construction remains one of the highest risk sectors, with over one fatality occurring each week despite the improvements made in recent years. The revised CDM Regulations aim to improve the level of health and safety performance in the construction industry by clarifying the responsibilities of each duty holder and focusing on effective planning and risk management.

Commenting on what is a landmark for the construction industry this year, Stephen Williams, Chief Inspector of Construction, HSE said: "*The industry has worked very closely with HSE to revise the CDM Regulations and ensure that there are clear benefits for all competent dutyholders. The Regulations clarify responsibilities of each duty holder and require greater focus on the risks to be managed by all involved in the construction process. Underlying all the changes is one simple aim - to reduce the unacceptable number of fatalities and injuries in the construction industry.*"

- The revised CDM Regulations will introduce the following changes:  
Clarify construction client responsibilities when they are exercising their influence over the health and safety standards on their projects.
- Replace the role of Planning Supervisor with a new role of CDM co-ordinator. The co-ordinator will act as the client's key advisor on health and safety issues, particularly effective communication and co-ordination of health and safety information.
- Emphasise the importance of competence at all levels in securing health and safety benefits, whilst simplifying the assessment of competence.
- Drive out needless health and safety paperwork and bureaucracy. Paperwork should be project-specific, relevant, proportionate to the risk, and of real use in helping to manage the risk.
- Simplify when a project is notifiable, and formal plans and appointments are required. Projects will be notifiable if they will involve more than 30 days or 500 person days of construction work. No projects for a domestic client will be notifiable. Formal plans and appointments are only required for notifiable projects. The CDM 2007 Regulations have been developed in line with the Government's Better Regulation principles and will consolidate and revise the main pieces of existing construction health and safety at work legislation, namely: the Construction (Design and Management) Regulations 1994 and the Construction (Health, Safety and Welfare) Regulations 1996- resulting in a single, simplified set of regulations.

Ed- time alone will tell whether these regulations live up to their billing. I must admit I'm sure I'll become nostalgic for the term "planning supervisor!"

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## BARROW LEGIONELLA FINAL REPORT

A report by the Health and Safety Executive into the Barrow Legionella outbreak sets out the steps that organisations need to take to avoid such outbreaks in the future, and what HSE intends to do to secure proper standards of control.

Colin Pickthall, the independent chair of the public meetings, said:

*"Like most accidents, this tragedy could have been avoided if the risks had been properly managed. This report follows two public meetings, held to explain to the people of Barrow and others what happened that summer. It describes the subsequent investigation, and highlights the lessons and recommendations to others to help prevent a comparable tragedy."*

Health and Safety Executive Regional Director David Ashton said:

*"Barrow has shown again how deadly legionella can be, but also that well-understood precautions will control the risk. This report explains both the technical steps, and the essentials of good health and safety management that can make sure a similar tragedy never happens again."*

The report, follows two public meetings held in Barrow in December 2006, aimed at providing an opportunity for members of the public, especially the families of those who died, to learn about the circumstances and causes of the outbreak and have their say, and identify lessons to be learned from it.

In August 2002, seven members of the public died and 180 people suffered ill health as a result of an outbreak of legionella from a council owned arts and leisure facility, Forum 28, in the town centre of Barrow-in-Furness. The public hearings followed the trials of Barrow Borough Council and Ms Beckingham. The hearings were restricted by the need to ensure that they did not prejudice any disciplinary / investigations still being undertaken by Barrow Council.

The meetings were chaired by Colin Pickthall and in his conclusions and recommendations found that:

- Effective lines of communication were needed;
- Systems were needed to ensure effective monitoring / workers should be encouraged to voice concerns without fear of reprisal;
- Risk assessments should be carried out by qualified staff;
- There should be greater co-ordination and clearly defined responsibilities for contractors;
- Proper training should be carried out for staff responsible for legionella control measures; and
- Individuals were reminded of their responsibilities under the Health and Safety at Work etc Act 1974 to take reasonable care for someone's health and safety.
- To address these needs the Health and Safety Executive has:
  - Produced a guidance video and inspection checklist, which helps companies and duty holders to check their actions against the standards.
  - Produced industry specific guidance
  - Provided specialist training courses through its Biological Agents Unit.
  - Continued its programme of inspecting legionella risk systems, cooling towers and evaporative condensers and where standards fall below requirement, take enforcement action.
  - Planned a nationwide inspection initiative in 2007/08 to assess and ensure that action is taken to reduce the risk.
- Set up a Legionella Working Group aimed at improving communication with internal and external stakeholders.

Also, by working closely with the Legionella Control Association, HSE aims to reach a large number of people working in the industry and help to ensure that the proper messages are being communicated, and through these measures continue to ensure that the risks associated with legionella risk systems are being properly controlled.

Colin Pickthall added:

*"Though emotions throughout the hearings were high, the self restraint and courtesy of those present, many of whom had suffered bereavement in the legionella outbreak and had waited many years for the opportunity to have their concerns addressed, was remarkable. This was despite a long running quest for 'culprits' by sections of the public and strident demands for resignations and sackings that generated much heat but little light.*

*The purpose of the hearings was to cast as much light as possible on the circumstances up to, during and after the outbreak, and to encourage those local citizens most affected to probe into the story, seeking the answers they had hitherto not secured. It was also most important that we should produce a report that would be useful in helping not only Barrow, but also other local authorities and other relevant organisations, avoid any repetition though negligence, mismanagement or ignorance, of Barrow's tragedy. Several awful flaws were apparent from the start.*

*The negligence of the Council in respect of the Forum 28 cooling tower over a long period of time and its lack of systems of control over such risks was dramatically summarised by the trial Judge. It was important to us that the lessons learned by the Council, Councillors, officers, staff and unions be made crystal clear.*

*While other public agencies performed well once the outbreak was spotted, there are still areas where procedures should be tightened, perhaps to the point of hyper-precaution, not least by strict adherence to readily available guidelines. This report seeks to address the long standing and deep concerns of the people of Barrow and their natural anxieties at the lethal outbreak of disease in their midst. We have sought also to make clear and practical recommendations so that some good may come out of this tragedy."*

Ed—The deaths from legionella in Barrow should be a warning to all of us to be vigilant. Cases like this make one wonder whether our public servants are up to the job. In these days of Blair's legacy do the testosterone fuelled micro-managed public servants have the opportunity to think about health and safety? Do the directors and managers of our public services take health and safety seriously enough? Lets not forget Barrow came about with officers not recognising the importance of legionella precautions and seeking to cut costs.

## OFFSHORE INSPECTION PROGRAMME

The key findings of a major offshore safety inspection programme have been presented to the oil industry. The programme was instigated following HSE concerns about injury statistics from deck and drilling operations in the North Sea. Over the last 18 months Inspectors from the HSE's Offshore Division have made 74 inspections of offshore installations focussed on the management of lifting operations, which have contributed significantly to occupational accidents in the offshore industry. At an open meeting in Dyce, Aberdeen, HSE informed the industry audience that although the inspections showed that some offshore installations were achieving reasonable standards in lifting safety, there were still too many instances where conditions and practices required improvement. Dave Forsyth, HSE's Programme Manager, said: *"I was surprised that our inspections found a general failure by offshore operators to carry out independent audits of their management of lifting operations. Independent audits are a fundamental requirement for effective safety management and corporate governance. Over the coming 12 months a key aspect of HSE's Offshore Division's work will be inspection of the industry's effectiveness in auditing. The industry should be taking action on this now"*. During the programme HSE served nine enforcement notices and made 173 written requests for action. HSE also advised that lifting and mechanical handling should remain key issues for the offshore industry, not only because the number of lifting incidents were rising and the number of experienced staff were dropping, but that there was a clear read-across to major hazard management.

## AVIAN FLU REPORT PUBLISHED

Defra has today published the final epidemiology report into the outbreak of H5N1 avian influenza in Suffolk confirmed in February.

The report sets out the findings of the National Emergency Epidemiology Group who have been investigating the outbreak in close consultation with the European Commission and the Hungarian Authorities.

The final report is a detailed analysis of all possible ways the virus could have arrived in Holton, Suffolk. No specific proven source has been found. The report concludes that the most plausible explanation is that infection was most likely introduced to Britain via the importation of turkey meat from Hungary. Such meat could have originated from a sub-clinically infected turkey flock in Hungary which had been infected from a wild bird source which had also infected the two goose farms in Hungary.

The investigation in conjunction with the Hungarian authorities has found no evidence of undisclosed infection in Hungary and the possibility of infection going undetected in turkeys is considered to be a rare event.

Debby Reynolds, Chief Veterinary Officer, said: "*The epidemiology investigation is an important part of increasing our understanding of avian influenza. Most potential routes of infection are controlled through current procedures. However, the outbreak in Suffolk appears to be the outcome of a series of normally low probability events and circumstances which cumulatively led to the introduction of disease. This report illustrates the importance of effective biosecurity for all food business operators, as there is a continuous low level risk of introduction of avian influenza to the UK. There are always lessons to be learnt after any outbreak and that process is underway. We will be working with the industry leaders and delivery agents on this and in particular examining all areas of biosecurity. A full report will be produced and published.*"

Defra has also confirmed today that payment will be made to Bernard Matthews for the clinically healthy birds slaughtered for disease control purposes at their premises in Suffolk, as required by the Animal Health Act 1981 (see 'notes to editors').

Ben Bradshaw, Minister for Animal Health, said: "*I would like to thank all those who have worked so hard to provide such a comprehensive report. I would also like to thank the Hungarian authorities for their co-operation and all of those who did such a brilliant job of containing and eradicating the outbreak in Suffolk. Although we cannot be sure how the outbreak happened, this episode reflects the need for constant vigilance, high levels of biosecurity and robust and well developed contingency planning in dealing with animal disease outbreaks.*"

Ed - The Food Standards Agency (FSA) announced on 2 April 2007 that, following a thorough investigation, there was insufficient evidence to provide a realistic prospect of conviction under:

- \* Animal By-Products Regulations 2005;
- \* Animal By-Products (Identification) Regulations 1995;
- \* or the Food Hygiene (England) Regulations 2006.

Bernard Matthews will receive reimbursement of £589,356.89 for the clinically healthy birds compulsorily killed to prevent disease spread, as required by the Animal Health Act 1981. The rules requiring payment for property destroyed are for disease prevention purposes. They act as an incentive to report disease early. Early reporting is essential to preventing disease spread, which would result in a far higher cost to the taxpayer.

## CONSTRUCTION SECTOR PLANS TO CUT FLY TIPPING AND LANDFILL

Proposals for reducing the 109 million tonnes of waste produced by the UK construction industry every year were published today for consultation.

Around 13% of all the solid materials delivered to construction sites goes unused, and up to one third ends up in landfill. Around a third of all fly tipping includes waste from the construction, demolition and excavation sectors. Today's consultation proposes to make Site Waste Management Plans a legal requirement for all projects in England worth over £250,000. Those responsible for Plans would need to assess the waste that will be produced on a construction site and detail how it will be reused, recycled or disposed of.

During construction, the Plans would be updated to record what actually happens to the waste, including the legitimate disposal of materials that cannot be reused or recycled. This audit trail would reduce the potential for fly-tipping and increase the accountability of contractors. Higher level reporting and review processes would apply to projects over £500,000. Site Waste Management Plans (SWMPs) should also help the construction industry to get maximum value out of its waste and make better use of resources.

Environment Minister Ben Bradshaw said:

*"The increasing number of construction projects up and down the country are indicative of a healthy, growing economy. But all this comes at a price. The UK's construction output is the second largest in the EU. The industry uses a tremendous amount of raw materials, much of which ends up as waste. Each year 400 million tonnes of solid materials are used in the UK construction industry but only two-thirds is added to the building stock. The rest is sent directly to landfill. Rising levels of waste crime are stopping us from achieving a sustainable construction sector, and rising numbers of fly-tips around the country, many of which are made up of construction and demolition waste, adversely affects the quality of life in many communities. It's essential that industry is seen to be taking this problem seriously. We can only expect householders to reduce their own waste if they understand that they do this as part of a much wider process which demands action from every one of us."*

The issues addressed in the consultation include whether to make SWMPs a statutory requirement or to continue the existing voluntary approach, the minimum level at which a project should require a SWMP, the level of detail they should offer, and how the SWMP can improve resource efficiency.

The anticipated benefits of SWMPs include:

- Saving the construction industry money. The savings to be made across the industry should far outweigh the cost of writing and implementing a SWMP, which for many companies will simply be a case of recording site management information on waste separately.
- Closing down the market for illegal waste operators by ensuring that only registered waste carriers and licensed waste management sites are used by those responsible for construction projects. This will improve the industry's compliance with the Duty of Care regime and should result in less fly-tipping of construction waste.
- Improving site safety by allocating specific areas for recycling and proper storage of materials. There is a strong correlation between poorly organised construction sites and high accident rates.

Ed - The Cabinet Office Inter-departmental Fly-Tipping Prevention group recommended in 2004 that the Government should develop the concept of site waste management plans as a way of controlling rising levels of waste crime involving construction and demolition waste, and as a way of improving resource efficiency within the construction sector. At the same time, DTI introduced a voluntary code of practice which some of the larger construction companies have adopted. Those that have adopted these or similar plans have reported significant savings in some cases.

Following consultation, the Government included powers in the Clean Neighbourhoods and Environment Act 2005 (CNEA) Bill to make regulations requiring those responsible for construction projects above a specified value to prepare plans to manage their waste before work begins on site and to implement them during the work.

## SOCIETAL RISK

The Health and Safety Executive has published a consultation document, seeking views on how best to deal with societal risk around non-nuclear major hazard sites.

Societal risk in this context is about the number of people, on-site or living or working in the areas around sites, that could be harmed by a single incident occurring at a site.

The risk of major accidents at such sites is very low. But because the risk cannot be completely eliminated, the planning system is used to exercise control over new development around them. HSE's role in this is to assess the risk levels and, when consulted by planning authorities on planning applications, advise them accordingly.

The Control of Major Accident Hazard Regulations 1999 required the operators of such sites to provide information to HSE about the likely potential effects of a major incident. HSE has used this information to produce initial indications of the level of societal risk around major hazard sites.

A cross-government group was established to consider how this information could be used in relation to the management of major hazard sites and the development of the land around them. The consultation document arises from the work of that group and has been agreed by the Government.

HSE Deputy Chief Executive Justin McCracken said, "*Industry and the regulators already work together to ensure that risks are as low as reasonably practicable. The risks to individuals are no higher than they were before and are comparable to those we face in everyday life. However, the public has a right to expect the information arising from the 1999 COMAH Regulations to be used when regulatory decisions are made. The aim is to ensure that societal risk data is used in the management of major hazard sites and by planning authorities when making their decisions. This will enable a balance to be struck between protecting the public on the one hand, and the social and economic growth of the surrounding community and industry on the other.*"

Mr McCracken went on to say, "*Ultimately it is for society as a whole to decide what is an acceptable level of risk around non-nuclear major hazard sites. Modern society has gained much from industrialization, including reliable fuel supplies and a wide range of products we use in everyday life. Society must therefore take a balanced view on how to weigh the risks and benefits of people and major hazard sites co-existing.*"

"*This consultation seeks views from all interested parties, including members of the public. We will take account of responses in our future recommendations to the Government.*"

## BETTER REGULATION OFFICE'S FIRST APPOINTMENT

Hilary Armstrong, Chancellor of the Duchy of Lancaster, has announced the appointment of Clive Grace as Chair of the Local Better Regulation Office (LBRO).

This is the first appointment to the LBRO which is being established as part of the Government's drive to make regulation simpler, more effective and better value for money.

Formally taking up his position in June, Clive Grace will set the strategic direction of the LBRO and head a board which will include people from a business background as well as those with central and local government experience. The LBRO will help drive up the performance of local authority regulatory services aiming to deliver significant reductions in the burdens of regulation on compliant businesses while maintaining regulatory outcomes. Its remit will initially cover local authority trading standards and environmental health services.

The organisation will be based in Birmingham.

Hilary Armstrong said: *"I'm very pleased to announce Clive Grace as the first Chair of the Local Better Regulation Office and that the organisation will be located in Birmingham. Success will depend on the drive, dynamism and creativity of its Board and senior staff as the challenges will be great but rewarding. This is a real opportunity to improve the regulatory framework and realise the substantial benefits for business, local authorities, consumers and the economy."*

Clive Grace said: *"This is a great opportunity, particularly at this formative point for the new organisation. There are many partners in the field of regulation and I look forward to engaging with them, as they will be paramount to the success of implementing better regulation at a local and regional level."*

Local authorities are partners in the better regulation agenda. Together, they make up the largest enforcer in the United Kingdom, inspecting more premises and enforcing more areas of law than any other.

Already, Peter Rogers, Chief Executive of Westminster City council, has published the recommendations of his review setting five priorities for local regulatory services and Professor Richard Macrory has reviewed regulatory penalties to ensure that they are proportionate. The LBRO will lead on implementing these important changes. This appointment was made in accordance with the Commissioner for Public Appointments' (OCPA) Code of Practice. All appointments are made on merit and political activity plays no part in the selection process. However, in accordance with the original Nolan recommendations, there is a requirement for appointees' political activity to be made public. Clive Grace has no declared political activity. The Chair appointment is remunerated at £50,000 for 80 days per year and will run from June 2007 to June 2012.

Ed—all this seems fine—but will it make a difference on the ground? Those of us working with local authorities know there are hot spots of enforcement and corresponding freezing wastelands of inactivity. One can only hope that enforcements of standards become reasonable and more uniform than they are.

In the days before Neil Hamilton became a disgraced MP and Minister he was responsible for better regulation under the John Major government. He expressed the view that a visit from the local Trading Standards Officers should be there as an aid to business comply with the law as opposed to being akin to a visit from the Gestapo!

## CINR, THE CENTRE FOR INTERDISCIPLINARY NANO-RESEARCH

The Health and Safety Laboratory (HSL) has announced that they will be launching an innovative Centre for Interdisciplinary Nano-Research (CiNR) towards the end of this month. This represents the latest step in a £1m programme of nanotechnology research funded by HSL in partnership with the HSE.

The HSL announcement follows the publication of a review of Government progress in the fields of NanoSciences and Nanotechnologies, last week by the Council for Science and Technology (CST).

The CST review, whilst generally critical of Government investment in nanoscience research, states: *"The HSE and HSL have committed substantial resources to nanotechnologies work, particularly for workplace exposure. Overall, CST finds that HSE and HSL have been thorough and conscientious authorities in the work that they have done to promote the safe development and handling of nanomaterials."*

The launch of the new CiNR will build on HSE and HSL's contribution to the wider research effort in this important area. Also, unlike most other 'centres of excellence' in the nanotechnology field, it will cover a range of expertise from 'Explosion to Exposure'.

*"The launch of the new Centre will enable HSL to translate its cutting-edge health and safety research into real workplace solutions for the nanotechnology industry,"* said HSL Chief Executive Eddie Morland.

*"We are committed to making the CiNR the most wide ranging and accessible centre in the UK to look at the potential risks and hazards in this somewhat unknown and fast moving field. Given the unusual breadth of our scientists' knowledge, we will be looking at everything from large scale explosion potential to the toxicological impact of these materials on the cell."*

HSL's nanotechnology-based research has already attracted some interest from industry and the new Centre will act as a focal point to enhance this important interaction. CiNR scientists and engineers will be actively engaging with a wide range of manufacturers, universities and other groups working with nanomaterials to provide both advice and practical research into their issues.

It is envisaged that the new CiNR will directly lead to a greater understanding and subsequent control of the potential health and safety issues relating to nanotechnology.

Ed - The HSE's involvement in nanotechnology started in the late 1990s with occupational hygiene interest in the manufacture and use of ultrafine particles such as carbon black and titanium dioxide, and exposure to inadvertently produced particles e.g. welding fume. Since then, it has evolved into being part of a pan-governmental programme to address the regulatory issues relating to nanomaterials. HSE input is on issues relevant to HSE's business (i.e. toxicology, occupational exposure and control and fire and explosion). However, HSE also contribute significantly on broader policy issues and human health matters and are members of the Nanotechnology Issues Dialogue Group (NIDG) and the Nanotechnology Research Coordination Group (NRCG).

The new "Centre for Interdisciplinary Nano-Research" at HSL will be launched towards the end of April 2007. The scope of work covers a range of capabilities including workplace monitoring and environmental exposure assessment, nanoparticle characterisation, control and filtration, toxicological assessment of nanoparticles, assessment and control of the fire and explosive potential of nanoparticles, personal protective equipment (PPE) including respiratory protective equipment (RPE), physiologically-based pharmacokinetic (PBPK) modelling, biological monitoring, and horizon scanning activities.

## HSE SUPPORT WORKERS MEMORIAL DAY

Workers' Memorial Day is commemorated to "remember the dead: fight for the living" and this year the HSE officially marked the day by planting a tree in memory of those who have lost their lives or been injured at work. In 2005/6 there was a total of 212 fatal injuries at work and a further 146,076 people were injured due to poor health and safety procedure in the workplace.

On Monday 30th April HSE's Chief Executive, Geoffrey Podger planted a tree at Red Grave Court, Liverpool. *"Injuries at work don't just affect the victim, but all those around them. It is our responsibility to ensure that all workers are given the protection they need and deserve to carry out their everyday duties and it is everyone's role to make sure this happens; trade unions, employees, regulators and the employers,"* he said.

*"Many accidents at work can be avoided by simple, low cost solutions. By preventing these accidents and working together, we can combat more workplace issues to reduce risks and promote safer working environments for everyone."*

Chair of the Health and Safety Commission, Bill Callaghan extended his support, *"Employers and employees must work together to ensure the highest standards of health and safety in the workplace. We remember those who lost their lives and our thoughts are with their families. Many of those 212 fatalities last year were avoidable and all of us in the health and safety system - whether in HSC/E, or an employer, trade union or professional body - need to work together in partnership."*



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We also intend to look at REACH and waste law shortly.

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