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BRUNSWICKS REGULATORY NEWS

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CORUS FINED £125,000

Corus UK Ltd pleaded guilty to 3 health and safety offences and have been fined £125,000 with an order to pay costs of £17,763 at Grimsby Crown Court. The prosecution follows an incident where an employee fell feet first into a pit of hot chemicals whilst carrying out a pumping operation at the company's site in Scunthorpe.

HSE Inspector Helen Berry said: "*This was a very serious incident which resulted in an employee receiving extensive, life-threatening burns. The immediate cause was the company's poor workplace maintenance regime which meant that corrosion went unattended in the fencing provided to prevent falls into the interceptor pit. Employers have a duty to ensure that their workplace is safely maintained and this case all too clearly demonstrates the potential consequences of failure to discharge that duty. In broader terms, however, the company had not carried out a risk assessment - a careful examination of what could cause harm to its employees. This is an all-important step when it comes both to protecting workers and to complying with the law. Accidents can ruin lives and workers have a right to be protected from harm. Employers are not expected to eliminate risk entirely, but they are required to take reasonable control measures to protect their staff. Had this been done, the outcome might well have been different in this case.*"

Corus UK Ltd were charged with breaching Regulation 3(1)(a) of the Management of Health and Safety at Work Regulations 1999 and breaching Regulation 5(1) and Regulation 5(2) of the workplace Health, Safety and Welfare regulations 1992.

DAIRY CREST'S MODEST FINE

Dairy Crest Ltd has been fined £5,000 and ordered to pay costs of £3,599 after pleading guilty to breaching the duty contained in s2(1) HSWA at the City of London Magistrates Court. The incident giving rise to the prosecution happened on 20th October 2005. Employee David Pennycook, 50, from Basildon, suffered two breaks and severe muscle and ligament damage to his left arm after a milk bottle filling machine started unexpectedly whilst his arm was inside an open hatch, the machine catching his sleeve and pulling his arm further in. Mr Pennycook required major reconstructive surgery to the ligaments and muscles in his arm to restore full use of his hand. He was off work for nearly a year.

The HSE investigation found that the hatch was guarded with a polycarbonate cover, fitted with an interlocking device, but this should not have been open at the time of the incident. If the interlocking device had been working properly the machine would not have re-started when the hatch was open. The investigation also found that Dairy Crest Ltd did not have an adequate management system in place to ensure checks on guards were carried out properly.
Gavin Pugh, HSE Inspector, said:
"*This incident shows that companies must ensure all work equipment is safe for use and have an adequate health and safety system in place. Safety equipment, such as the interlocking device is there to protect the operator. It's vital that machinery is kept in full working order otherwise accidents like this could continue to happen. It was Dairy Crest Ltd's responsibility to ensure these items were kept in full working order*. "

Ed-some may think Dairy Crest got off lightly—although I do recall acting for an internationally renown food company where 2 employees were injured with penetrative injuries in successive weeks on a tubbing machine and escaped prosecution!

It is summer time with a slackening of pace so BRN is shorter!

ASSETS SEIZED FOLLOWING UNLAWFUL DISPOSAL

The Assets Recovery Agency (ARA), working in partnership with the Environment Agency, has obtained restraint orders to freeze properties belonging to a Bradford man convicted of illegally dumping asbestos and excavation waste.

The ARA's investigation follows the conviction of William John Peter Reidy, aged 60, of Bradford. The prosecution against Mr Reidy was brought by the Environment Agency following their detection of illegal activities of his demolition business called Space Making Development. In spite of not holding a waste management licence, the firm was being paid to take building waste away from companies across Yorkshire. Officers from the Environment Agency carried out surveillance on the site and estimated that a total of 200 lorry loads of waste had been illegally dumped. A skip containing asbestos sheeting was also discovered, for which the business did not hold a licence.

Mr Reidy was sentenced to 16 months' imprisonment of each of four charges relating to the keeping and depositing of waste, including asbestos waste. The sentences were ordered to run concurrently, as were further sentences of three months for each of nine further waste charges.

The ARA is investigating whether and to what extent, the defendant benefited from his illegal activities and will seek to recover assets equal to a value of the benefit if that is established. Commenting on this stage of the criminal confiscation process, ARA Interim Director Alan McQuillan said: "*We are determined to recover the proceeds from all types of illegal activity, including illegal dumping and fly-tipping which, as well as damaging the environment, poses a risk to human health. This restraint order will prevent the disposal of the assets belonging to Mr Reidy while we continue with our investigation to establish the full scale of the benefit obtained from this criminal conduct, thus assisting the court to make any appropriate confiscation orders. The restraint and any confiscation of assets sends a clear message to others involved in illegal activities that we are dedicated to recover the proceeds of illegal activities and that crime does not pay.*"

Paul Salter, Environmental Crime Officer at the Environment Agency, explained: "*This is the first time that assets have been seized in a case like this and shows that businesses cannot get away with putting profits before the environment and human health - as this case shows. If you are an offender, we will track you down and take you to court. We can then refer the case to the Assets Recovery Agency which will endeavour to confiscate any monies and assets made from these ill-gotten gains. Demolition contractors must take their responsibilities seriously as people will not put up with them blighting our towns and countryside.*"

Ed—The Proceeds of Crime Act 2002 created the Assets Recovery Agency. In addition to confiscation proceedings following a criminal conviction the ARA can seek civil recovery of the proceeds of unlawful activity by an action in the High Court. The Agency can also issue tax assessments where there are reasonable grounds to suspect that there is taxable income, gain or profit from criminal conduct. In addition to these powers, the Agency offers its expertise to other agencies to assist them in confiscating criminal assets. Under the Government's Asset Recovery Strategy initiative 'Payback', the tracing of and recovery of assets is seen as an important element in the delivery of justice. The aims of the strategy are to make greater use of the investigations of criminal assets in the fight against crime; recover money that has been made from crime or which is intended for use in crime; prevent criminals and their associates from laundering the proceeds of criminal conduct, and detect and penalise such laundering where it occurs; to use the proceeds recovered for the benefit of the community. On 11th January 2007, the Home Office laid a Written Ministerial Statement before Parliament setting out Government proposals to merge the Assets Recovery Agency (ARA) with the Serious Organised Crime Agency (SOCA), and to extend to prosecutors the power to launch civil recovery action under the Proceeds of Crime Act 2002. The Written Ministerial Statement can be viewed at **http://www.assetsrecovery.gov.uk/AboutARA/**

I have witnessed the ARA in action first hand. Anyone convicted of any offence, and goodness knows there are myriad regulatory offences, where it can be argued that unjust enrichment has occurred can give rise to a claim. More problematic for those of us who believe in civil liberties is that the ARA has been given a fiscal target to achieve in terms of recoveries. I acted in a case where a claim for £1M plus was made by the ARA arising from a regulatory irregularity. The Judge, gave very strong advice to the ARA to drop the matter—which duly occurred. But the warning to all is there. In addition to fines and damage to reputational damage any proceeds of a regulatory irregularity such as a non-payment of landfill tax, or commercial transactions taking place without a requisite licence (eg Consumer Credit) can end up with ruinous confiscations. Did Parliament intend this?

WEAR VALLEY DISTRICT COUNCIL FINED FOR ASBESTOS OFFENCES

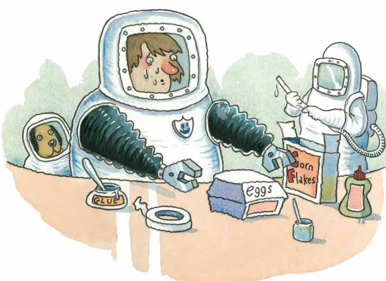
Wear Valley District Council has been fined £18,000 at Darlington Magistrates Court this afternoon after admitting six offences under the Control of Asbestos at Work Regulations 2002. It was also ordered to pay £7,722 costs.

The investigation followed a complaint in January 2006 by a maintenance worker, who discovered that the plant room of the council-run leisure centre where he had worked for many years contained asbestos.   Health and Safety inspector , Richard Bishop, said: "*A survey had been carried out in 2001 which identified asbestos containing materials. This information was not acted upon and no-one who worked in the plant room was made aware. As a result, work that was liable to disturb the asbestos was done without the necessary precautions required by law to protect their health from exposure. This case should serve as a warning, not only to Local Authorities, but to everyone responsible for carrying out or contracting maintenance work on buildings where asbestos may be present.   With up to 4,000 deaths per year - that's around 15 times the current rate of fatal accidents at work - asbestos-related diseases are the largest occupational killers in the UK. There is still a legacy of asbestos in buildings that needs addressing. It is estimated that some half a million non-domestic premises contain asbestos of some type. And this means there are still workers putting themselves at risk every day. Recent studies estimate that a quarter of those dying from an asbestos-related disease worked as electricians, plumbers, maintenance workers or builders.   Where asbestos has been found to be present in buildings, the risk it presents must be evaluated and written plans devised and implemented that specify the steps necessary to address the risk. All work liable to expose people to asbestos must be carefully planned and assessed, with appropriate precautions taken to prevent or reduce exposure and the spread of asbestos.*"

Ed- Wear Valley District Council admitted and were convicted of six offences under the Control of Asbestos at Work Regulations 2002 (now repealed and replaced by the Control of Asbestos Regulations 2006):
regulation 4(8), which requires dutyholders to ensure that, where an assessment has shown that asbestos is present in any part of their premises, the risk from that asbestos is evaluated, and a written plan is prepared which identifies the relevant parts of the premises and the measures which need to be taken for managing the risk;   regulation 6(1), which requires employers to ensure that work liable to expose employees to asbestos is not carried out unless there is a suitable and sufficient assessment which identifies the risks and the steps that need to be taken to achieve effective control of exposure; regulation 7(1), which requires employers to ensure that work with asbestos is not undertaken unless a suitable written plan of work has been prepared which details exactly how that particular work is to be carried out;   regulation 9(1), which requires employers to provide employees with adequate information, instruction and training;   regulation 10(1), which requires employers to either prevent or reduce employees' exposure to asbestos to the lowest level reasonably practicable; and regulation 15, which requires employers to either prevent or reduce the spread of asbestos to the lowest level reasonably practicable from any place where work under their control is carried out.
Relevant HSE guidance relating to the control of asbestos includes:
- L127 - The management of asbestos in non-domestic premises - Approved Code of Practice and Guidance to regulation 4 of the Control of Asbestos Regulations 2006 (ISBN 0-7176-6209-8)
- L143 - Work with materials containing asbestos - Approved Code of Practice and Guidance to the Control of Asbestos Regulations 2006 (ISBN 0-7176-6206-7)
- HSG227 - A comprehensive guide to managing asbestos in premises (ISBN 0-7176-2381-5)
- HSG210 - Asbestos essentials task manual (ISBN 0-7176-1887-3)
Who knows whether there will be long term health effects from this discovery. What were the Council officers and Councillors actually doing—sleeping on watch? If a maintenance man realised there were problems what were the managers doing?

HSE'S MYTH OF THE MONTH

The HSE's copyright is duly acknowledged. Go and see their excellent cartoons www.hse.gov.uk/myths



The myth Egg boxes are banned in craft lessons as they might cause salmonella
The reality This story started after a school briefly banned children from using cardboard egg boxes to make things, threatening years of Blue Peter tradition. They were concerned that children might catch salmonella.
Within a few days the school realised there was guidance from the county council and an organisation for teachers called CLEAPSS, making clear that as long as egg boxes and toilet roll centres look clean, there is no reason why they should not be used. Just another storm in an egg cup…

FATALITIES BRING £400,000 IN FINES

ICL Plastics Ltd has been fined £200,000 at the High Court at Glasgow, having earlier pleaded guilty to a breach of Section 2 and Section 4 HSWA and associate company, ICL Tech Ltd has been fined £200,000 after pleading guilty to a breach of Section 2 and Section 3 HSWA.

Stewart Campbell, HSE Director Scotland said:
"*Our first thoughts remain with the families and friends of those who died, and the many other people who were injured in this tragic incident. The scale, complexity and challenge of our investigation was massive, and was pursued through an innovative joint investigation involving HSE/HSL, Strathclyde Police and Crown Office and the Procurator Fiscal Service (COPFS). The investigation necessitated effective co-ordination and co-operation between the investigators and the commitment of substantial resource. HSE/HSL drew on their investigative and forensic expertise to identify the cause of the explosion as a leak from a corroded pipe carrying Liquefied Petroleum Gas (LPG). The LPG then accumulated in an unventilated room, and the ignition of this LPG caused an explosion of sufficient force to cause the building to collapse."*

Mr Campbell continued:
"*It is important for all those affected by the explosion that lessons are learned and I would like to remind all users and suppliers of LPG of the risk from buried pipes carrying LPG, particularly when located near areas where gas can accumulate. Everyone should ensure that problems which are out of sight are not out of mind. The dangers posed by buried pipes can be overcome by a systematic approach to risk management and the findings of the investigation reinforce the need for effective arrangements for the maintenance, renewal or repositioning of buried pipes. HSE strongly advises that buried metallic pipes are effectively corrosion protected and maintained, or replaced either with over ground pipes or buried plastic pipes constructed and installed to the appropriate standards*."

Ed- ICL Plastics Ltd were charged under Health and Safety at Work Act 1974 section 2 and section 4 in that they did not ensure the safety of their employees and others in that they failed to carry out a suitable and sufficient risk assessment or have a proper system to inspect and maintain the LPG pipe.
ICL Tech Ltd were charged under Health and Safety at Work Act 1974 section 2 and section 3 in that they did not ensure the safety of their employees and others in that they failed to carry out a suitable and sufficient risk assessment or have a proper system to inspect and maintain the LPG pipe.

The HSE in Scotland have published a fact sheet on this incident which is worth reproducing in full:

Fact Sheet
Date of incident: Tuesday 11 May 2004
Location: Premises occupied by ICL Plastics Ltd and ICL Tech Ltd at Grovepark Mills, Hopehill Road, Maryhill, Glasgow, G20 7NF.
Brief Summary of Incident: At approximately 12.00 noon an explosion occurred at the above location. This caused the building to collapse, which resulted in the death of 9 employees and seriously injured 40 others including a member of the public.
Brief Description of Premises: Grovepark Mills was originally built in 1878 as a weaving mill. ICL plastics occupied the premises in 1968. At the time of the incident there were 3 buildings on site; the main building (the site of the accident), the fabrication building and the Stockline Plastics building. The main mill building consisted of a basement, ground and three additional floors. The main production areas (coating shop and despatch area) were on the ground floor, and the office accommodation was on the second floor. The basement, which was beneath the despatch area, had a ceiling, which comprised of a steel structure with concrete slab infill. The main access to the building was via a yard on the south side of the building off Grovepark Place. In the south corner of the yard was a Liquefied Petroleum Gas (LPG) tank.
Description of ICL Tech Ltd/ICL Technical Plastics Ltd: ICL Technical Plastics Ltd were incorporated in Edinburgh on 26 November 1973. The company changed its name to ICL Tech Ltd in 1999 and it is stated that the principal business activity of the company is "The manufacture of other plastic products".
Details of the Joint Investigation: It was announced on 19 May 2004 that the Health & Safety Executive (HSE) and Strathclyde Police would conduct a joint investigation reporting to the Area Procurator Fiscal. A team of HSE inspectors and HSE/HSL specialists worked with police officers during the investigation. The investigation followed lines of enquiry developed from possible causes of an explosion based on the examination of the site. HSE submitted a report to the Procurator Fiscal in 2005. The HSE investigation was led by Stewart Campbell, HSE Director Scotland, and the Investigation team manager

Jim Young, HM Principal Inspector, with HM Inspectors, Bill Reilly, Stephanie Rafferty and Garry Stimpson forming the core investigation team. Russell Breen, HM Principal Specialist Inspector , was the Technical Support Manager, with responsibility to coordinate the scientific and expert support assisted by HM Specialist Inspector, Mike Thompson. A large number of other HSE staff have also been involved in the investigation, providing investigative support, or corporate or expert opinion, including Sandra Caldwell, Director, FOD, Ian Waugh, Head of HID Specialised Industries Division, and Penny Taylor HID/LPG policy. HSL staff primarily involved included Dr Stuart Hawksworth and Dr Roy Parrott. Since the investigation moved into the active prosecution phase, FOD's work has also been supported by Jeanette Reuben, Head of Operations, and Trevor Johnson HM Principal Inspector, and HSL's work taken under the overall supervision of Phil Heyes, Senior Investigation Manager.

Summary of the Investigation's main findings:

Clear evidence was found of forces characteristic of a gas or dust explosion having acted on the underside of a steel structure that formed the ceiling of the basement. These forces damaged the I-section steel frame, welds and checker plate. From analysis of the mechanical damage to the steel structure, the explosion overpressure produced in the basement is at least 692 mbar (Equivalent to 7 tonnes per square metre), but may have been greater than this.

The overpressure produced during the explosion violently lifted and broke apart the dispatch floor/ground floor. This happened in a number of stages as the explosion developed over several seconds. Initially it appears to have lifted the steel structure breaking it apart from its supporting legs. The welds holding the checker plate covering in place then failed. At some stage the concrete floor section also broke apart. These events resulted in the explosion venting into the ground floor space above the basement causing the collapse of the building as the force of the explosion pushed the walls outward, allowing the floor supports to fall.

A number of potential sources for the explosive atmosphere were identified which include LPG, natural gas and possibly organic dusts or solvents. However, the evidence indicated that of these the only credible source of the explosive atmosphere was a leak from a failed underground LPG pipe. The pipe was not installed nor maintained to an acceptable standard.

The failure in the LPG pipe was adjacent to the basement wall, and tracer gas testing showed the availability of a leakage path from the failure to the inside of the basement. An investigation of the potential for the occurrence of flammable gases in the ground at the ICL site revealed a plume of propane in the ground consistent with leakage from the LPG supply pipe.

From the evidence available the explosion did not involve mains natural gas, process dust or solvent, as they were not present in the basement nor the ground floor dispatch area above the basement. There is no credible mechanism for flammable atmospheres of natural gas, dust or solvents to have entered the basement.

The possibility of explosive gases from natural sources, e.g. coal seams, was fully considered and its likelihood was determined as remote.

Reasonable Practicable Precautions:

The approach HSE recommends to employers who use LPG:

* Make sure that problems which are out of sight are not out of mind.
* Ask - do you have a LPG supply?
* If you have LPG -where does the pipework go?
* If sections are buried - is it metal and is it protected?
* If it is not protected against corrosion, then its condition should be urgently assessed, and if necessary the pipework taken out of use.
* If you have corrosion-protected buried metal pipework, you need competent advice on a scheme of inspection and maintenance;
* But this may not be easy (competent advice difficult to obtain, or buried in an awkward position), so two simpler options - put it above ground, OR replace by plastic piping and mark clearly (plastic pipe will have a normal life expectancy and can then be replaced);
* Remember problem is worse and needs an enhanced precautionary approach, if buried pipework near low areas where gas can accumulate. All commercial/industrial users of bulk LPG should already have been approached by their suppliers and provided with a guidance leaflet; if you have not been, then contact your LPG supplier.

Properties of LPG: LPG is a generic term for gases, most commonly propane and butane, having the characteristic of being easily liquefied by application of moderate pressure. A litre of liquid LPG will provide approximately 250 litres of gas. LPG is approx 11/2 times heavier than air. LPG forms a flammable vapour when mixed with air in proportions of between approximately 2% and 10%.

WORK PLACE TRANSPORT FAILURES

W. E. & I. Wright Limited have been fined £4,000 for breaching s2 HSWA 1974. Their prosecution followed an accident to one of their employees, who was seriously injured after being trapped and crushed between two heavy goods vehicles as one reversed past the other. The investigation by the HSE showed a number of deficiencies in the company's arrangements to ensure safety during reversing operations. These deficiencies were identified as putting employees at serious risk of injury from being struck by a reversing vehicle.

As a result of the prosecution, W. E. & I. Wright Ltd was fined £4,000 at Durham Magistrates Court on 29 August 2007 after admitting it had breached section 2(1) of the Health and Safety at Work etc Act 1974. The company was also ordered to pay £2,500 in costs.

Health and Safety Inspector Richard Bishop told the court that his investigation found that the company had been alerted to the risks less than a year before the accident, when it commissioned the Road Haulage Association (RHA) to carry out risk assessments at its premises. However, the precautions identified by the risk assessments were not implemented, meaning that the company had almost no physical or organisational measures in place to control workplace transport risks.

Speaking after the case, Mr Bishop said: "*Vehicles are a part of everyday life, and as a result their dangers are often overlooked - complacency can be a real problem. But workplace transport continues to be the second biggest cause of fatal accidents at work. In 2004/05 there were 70 deaths and over 2,000 major injuries involving vehicles at work. Reversing alone caused about a quarter of the fatal accidents. An employer's first consideration should always be to try and eliminate reversing at their premises. But where reversing cannot be avoided, there is clear guidance that spells out how to plan for safety, which should involve taking sensible, cost-effective measures to ensure a safe site, safe vehicles and safe drivers."*

Ed-Workplace transport is the second largest cause of fatal accidents to workers in the UK, and bringing about a reduction in this kind of accident is a priority for HSE. The main causes of accidents are being struck by a moving vehicle, falling off a vehicle (or its load), loads falling off vehicles, and vehicles overturning. Workplace transport is likely to be a significant hazard at many workplaces, and it is a topic that is raised proactively at most visits carried out by HSE Inspectors.
Guidance: The key reference is HSE's guidance publication HSG136 - 'Workplace transport safety' (2nd edition, ISBN 0-7176-6154-7). This can be obtained from HSE Books, PO Box 1999, Sudbury, Suffolk CO10 2WA, tel: 01787-881165 or fax: 01787-313995.

There is nothing worse for a defendant than the authorities coming across an unactioned report. Evidence of knowledge of the risks and what could be done to control them is readily at hand—and therefore brings almost certain convictions.

OVERLOADED FERRY BRINGS PROSECUTION

Lower Thames and Medway Passenger Boat Company Limited has been fined a total of £18,000 plus a £9,000 costs award for allowing their vessel to carry more passenger than was allowed for by the vessels certification. The Duchess M is a vessel which operates the Gravesend to Tilbury ferry service. On the evening of the 30th August 2006 the Duchess M was due to commence a voyage from Gravesend to Tilbury. The Port of London Authority (PLA) at Gravesend received a phone call stating that the Duchess M was carrying 90 passengers. On departing Gravesend terminal the Duchess M reported to PLA Gravesend that it was carrying 62 passengers. Observations using CCTV and crew on a nearby PLA launch confirmed that the Duchess M was carrying persons onboard well in excess of the permitted level of 60 passengers plus 2 or 3 crew. Estimates of the number carried as between 90 and 110. The matter was reported to the MCA who started an investigation into the incident which led to this prosecution.
The owner of the ferry Duchess M pleaded guilty to one offence under the Merchant Shipping (Survey and Certification) Regulations 1995 for allowing the vessel to proceed on a voyage with a greater number of passengers onboard than that stated on the ship's Passenger Certificate. The Lower Thames and Medway Passenger Boat Company Limited were fined £18,000. Costs of £9,000 were also awarded against the company.
Bryan Hopkins, Area Operations Manager with responsibility for the River Thames at the MCA, said "*Carrying more passengers onboard than is allowed by the vessels certification is dangerous as the vessels lifesaving equipment, construction and stability may not be sufficient for the numbers onboard. Also the reporting of 62 passengers to PLA Gravesend could have had serious consequences. The limits set out in the ships certification is there for the protection of the public and seafarer.*"

PANN KRISP IN HOT WATER?

Pann Krisp Ltd, based at Wrexham Industrial Park, has pleaded guilty to two breaches Section 2(1) HSWA 1974 for which it was fined £25,000 and ordered to pay £8,696 costs at Wrexham Magistrates Court.

Employee Percy Vaughan Guest was run over by a forklift truck resulting in both his legs being broken, leaving him unable to walk for almost two years. Another employee, Patrick Brindley was injured when the truck he was operating fell down a gap between a refrigerated trailer and a loading platform. Both incidents occurred in July 2005.

HSE inspector Stephen Window said, "*Both incidents demonstrated the clear need for employers who have vehicles in the workplace to have clear risk assessments and clear procedures in place for their operation.*
"Incidents with forklift trucks are far too common, and they invariably result in serious injury. Where possible, pedestrians should be segregated from vehicles to minimise the risk of the two coming into contact, and drivers need to be trained - and if necessary regularly re-trained - on safe operation within workplaces."

Ed- For the charges in relation to Mr Vaughan Guests the fine was £15,000 and costs were £6,311and for the charges in relation to Mr Brindley the fine was £10,000 and costs of £2,385.

£50,000 FINE FOR FATALITY

Central Demolition Limited of Bonnyside Road, Bonnybridge has been fined £50,000 at Edinburgh Sheriff Court having pleaded guilty to a breach of their s2 HSWA duty owed to their employees. Mr Gideon Irvine, aged 44 of Falkirk, died on Sunday 22 August 2004 when a large section of the former Caledonia Mill which was being demolished at the time, fell onto him without warning as he was operating an excavator on the site.

HSE Inspector Murray Provan commented after the case:
"*This accident was entirely foreseeable. The demolition company had not carried out a survey of Caledonia Mill as they had been contracted to do and as health and safety legislation and the British Standard for Demolition strongly suggests should be done in order to identify structural hazards to prevent premature collapse. The company relied entirely on drawings prepared around 1989 but made no effort to search archives or pursue other reasonable lines of enquiry to find out as much as it could about the large silo building at Caledonia Mill. The building itself was actually two separate structures, built at different times, but, superficially, similar in appearance. The company did not seek the advice of a competent structural engineer, who would have been able to spot the differences between the structures very quickly. His advice would have crucial in preventing the collapse of the last section of the "new" building which abutted directly onto the "older "part of the building. Central Demolition's involvement at this site went back several years and it had ample opportunity to find out as much as it could. The company failed entirely to appreciate the differences in the structure and it was therefore inevitable that part of the silo would collapse prematurely. Demolition is an inherently risky part of the construction industry. The very nature of the work involves bringing buildings or other structures down and there is plenty of advice and guidance on how to do this work safely and with the minimum of risk to workers and members of the public*."

RIVER WATER QUALITY IMPROVING SLOWLY

In a flurry of statistics DEFRA has released data suggesting that river water quality is improving—albeit slowly. The data considers many parameters including chemical and biological water quality. For example In England 71 % of river length was of good biological quality in 2006, the same as in 2005, and compared to 67% in 2000 and 60% in 1990
In Wales: 82% of river length was of good biological quality in 2006, up from 80% in 2005, 78% in 2000 and 79% in 1990 .
In N. Ireland 54% of river length was of good biological quality in 2006, down from 56% in 2005 and 61% per cent in 2000.
For Scotland the data set is based on different parameters—but with around 88% of river length being considered of good quality—a remarkably consistent figure over the years. Overall for the UK the figure is believed to be 76% of river length being of good quality.
See the Environment Agency web site and the Scottish and N Irish equivalents for the full data set.

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MORE BUNCEFIELD RECOMENDATIONS

The Buncefield Major Incident Investigation Board (MIIB) has published the Explosion Mechanism Advisory Group report, outlining the work required for better understanding of the severe explosion that took place at the Buncefield oil depot on 11th December, 2005. From the outset the Board wanted to understand the explosion mechanism that produced such a forceful explosion with high overpressures. The Board agreed that such understanding would provide further material assistance in guiding the design and operation of sites that store large quantities of vaporising flammable materials.

Professor Dougal Drysdale, an independent member of the Buncefield Board, convened an Advisory Group of explosion experts from academia and industry to begin this work and evaluate the evidence from the explosion. Professor Drysdale said:

"*Understanding the explosion further is a matter of international interest and I am pleased to say the Advisory Group has been able to identify lines of further investigation that give rise to a reasonable prospect that we will be able to explain the violence of the Buncefield explosion. I must stress that this is work in hand and not concluded. It will take some time, possibly several years, to complete the research necessary to deliver sound guidance to the Industry. We therefore believe that it is of the utmost importance that the recommendations in this report are implemented without delay.*"

Ed—1. The Buncefield Major Incident Investigation Board (MIIB) has been overseeing a comprehensive investigation of the incident and has published a number of reports on its findings. One important aspect of the incident was that an explosion of unprecedented violence took place. The reports identify that the incident occurred following a spillage of unleaded petrol from one of the storage tanks.

2. In its 'Initial' report published in July 2006, the MIIB stated that:

'Further work is needed to research the actual mechanism for generating the unexpectedly high explosion over-pressures seen at Buncefield. This is a matter of keen international interest, and participation from a broad range of experts, as well as the industry, is essential to ensure the transparency and credibility of any research programme. The Board will consider further recommendations about the nature and scope of such work.'

In its report on 'Recommendations on the Design and Operation of Fuel Storage Sites', published in March 2007, the MIIB stated that:

'We have asked the panel (Advisory Group) to advise us whether research is justified and if so the scope of such research, likely methods of funding it, and its governance arrangements, to ensure a satisfactory outcome.'

This report is the response to this request and provides a summary of the technical issues examined by the Advisory Group along with its conclusions and recommendations.

3. A proposal for the joint industry project has been prepared by the Advisory Group, with work recommended to start as soon as possible. The cost of the first phase of the project is estimated at not more than £200,000, to be completed in early 2008. Any additional experimental and theoretical work should then be complete in the following 18-24 months. The proposed governance of the project is a steering committee, made up of stakeholders from industry and the Health and Safety Executive as regulator.

4. The Buncefield Investigation Board was appointed by the Health and Safety Commission (HSC) to supervise the investigation into the explosions and fire at the Buncefield oil storage and transfer depot, Hemel Hempstead, Hertfordshire, on 11 December 2005. The HSC directed the investigation using its powers under section 14(2)(a) of the Health and Safety at Work etc Act 1974, to be carried out jointly by the Health and Safety Executive (HSE) and the Environment Agency (EA). The Investigation Board is independent of HSE and EA, while including representatives of HSE and EA as well as independent experts. The Board is chaired by Lord Newton of Braintree.

5. The Competent Authority manage and enforce the Control of Major Accident Hazards Regulations (COMAH) and comprise of the Health and Safety Executive (HSE) and the Environment Agency in England and Wales (EA), and the HSE and the Scottish Environment Protection Agency in Scotland.

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