



Prosecutions

Scrap yard Grab Claw Fatality

The death of a man crushed by a scrapyard grab claw has prompted a prosecution by the Health and Safety Executive (HSE) and a £50,000 fine.

James Huntley & Sons Ltd of Sholing, Southampton, pleaded guilty to breaching section 3(1) of the Health and Safety at Work etc. Act 1974 and contravening Regulation 3(6) of the Management of Health and Safety at Work Regulations 1999 at Southampton Magistrates Court.

Barry Collins from Millbrook, Southampton was killed when he and his brother, Joey Collins, visited the site run by metal recyclers James Huntley & Sons Ltd in Sholing, Southampton on 2 August 2007. They were examining a vehicle for its parts and entered the site by the open back gate while the grab claw crane operator was elsewhere.

Barry Collins was inside the van when the crane operator came back to start work. Despite his brother, Joey, trying to tell the crane driver that Barry was in the van, the operator misunderstood and thought he was being asked to pick up the van.

As the crane picked up the vehicle Barry Collins was in, he was instantly crushed by the crane's five-finger grab. He died at the scene.

The company was fined £50,000 and ordered to pay costs of £34,373.80.

Salus Be Wise

Health and safety law requires that a risk assessment is carried out in respect of any work processes in the workplace and to take or observe appropriate special, technical or organisational measures.

In addition, employers' general preventive and protective duties (implicit in the 1974 Act) are made explicit by the Management of Health & Safety at Work Regulations 1999. For example:

- avoiding risks
- evaluating the risks which cannot be avoided
- combating the risks at source
- adapting the work to the individual
- adapting to technical progress
- replacing the dangerous by the non-dangerous or the less dangerous
- developing a coherent overall prevention policy
- giving collective protective measures priority over individual protective measures
- giving appropriate instructions to employees.

These strategies are to be used when implementing risk management measures. In appointing competent people to help employers meet their statutory duty, there is a requirement to prefer a competent person in the employer's employment, rather than a consultant or other person.

Salus' service offers a range of tools that can help.

The above incident could have been prevented through many means, including:

- legislation (Health and Safety at Work etc. Act 1974)
- legislation (Management of health and safety at work Regulations 1999)
- guidance (guidelines for waste management and recycling industry)



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- information (Safety at sites in waste management and recycling industries)
- Risk Assessment of General Workplace Hazards.

Sellafield Fined After Contractors Inhale Radioactive Dust

Sellafield Ltd has been fined £75,000 after pleading guilty to breaches of health and safety law after two contractors inhaled radioactive contamination. The prosecution follows an investigation by the Health and Safety Executive (HSE) into an incident on 11 July 2007 at Sellafield Nuclear Licensed Site in Cumbria.

Sellafield Ltd pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. The company was fined £75,000 and ordered to pay costs of £26,100 at Carlisle Crown Court.

The incident happened while removing radioactive contamination from an area of concrete floor in a room formerly used to sort and monitor material contaminated with plutonium. A patch of concrete floor, believed to be contaminated with radiation from spillage some years ago, was being drilled prior to being removed.

Two contractors were drilling an area of the floor, under Sellafield Ltd's supervision, when they were contaminated with plutonium by the dust produced from the drilling, some of which they inhaled. There was no immediate impact on their health, but they received a significant radiation dose below annual dose limits.

The two workers were monitored, undressed and removed from the enclosure. One contractor had widespread contamination on his PVC suit and while he was undressing two radiation air monitors outside the enclosed area were triggered. The enclosure was later found to be heavily contaminated.

Mark Bassett, HSE's Superintending Nuclear Inspector, said:

"Although the radiation doses in this case were below the statutory dose limits, they could potentially have been higher. They should have been zero. The incident highlights the importance of Sellafield Ltd following its own arrangements for protecting workers, when undertaking potentially hazardous work with the risk of exposure to radiation. Sellafield Ltd should have properly assessed those risks, and then appropriately planned, organised and carried out the work."

Man Crushed to Death by Lorry

A commercial vehicle repair centre in Kettering has been fined £40,000 and ordered to pay £25,000 costs after an employee was crushed to death underneath a 24-tonne lorry. FW Abbott Ltd (Pytchley Road, Kettering) pleaded guilty at Northampton Crown Court to health and safety breaches which led to the death of Martin John Carswell of Wellingborough.

Mr Carswell was working underneath a 24-tonne road drain cleaning vehicle when the equipment supporting it collapsed. The employer breached section 2(1) of the Health & Safety at Work etc. Act 1974 for failing to train employees in a safe system of work for raising and working beneath vehicles. The court was told that there were no health and safety systems in place to ensure that employees followed safe practices.

On 9 June 2007 Mr Carswell was carrying out repairs to a four-axle, eight-wheel lorry. He used four hydraulic lifts to raise the vehicle up to around six feet but instead of putting them on the front and fourth axles as is common practice, he put them on the front and third axle. After raising the lorry, it is thought that Mr Carswell wanted to rotate the wheels on the third axle so he placed a single tall axle stand under the middle fourth axle.

He then lowered the lifts so that the wheels on the third axle were able to rotate. It appears that as he went to adjust the brakes of the third axle, the vehicle wobbled and the axle stand collapsed. As it fell, the rear of the vehicle bounced into the hydraulic lifts, knocking them away from the wheels, allowing the lorry to fall on to Mr Carswell.

The court heard that there were two axle stands available, but Mr Carswell had only used one. Each stand had a safe working load of 7.5 tonnes which, if used together, would have been adequate to support the rear of the vehicle, but the single stand used would have been massively overloaded.



News

Foamed Concrete Explosion

The Health and Safety Executive (HSE) has released information on an explosion involving foamed concrete. The aim is to provide interim advice whilst the HSE continues its investigation.

In August 2009, there was an explosion which injured two people. A contractor had filled a pit with about 6m depth of foamed concrete. Whilst the concrete was setting, workers started removing steelwork using angle grinders. There was an explosion underneath the steel walkway on which two contractors were standing and which blew the steel plates and the workers up into the roof.

The foaming agent in this concrete mix was air produced by the addition of surfactants and agitation. It appears that while the concrete was setting, the flammable gas hydrogen was produced. The particular location of the pour within a relatively confined area beneath a walkway appears to have allowed a flammable/explosive mixture to have developed.

The HSE investigation is looking at the means by which hydrogen was generated. Aluminium is known to react with cement/concrete mixtures to form hydrogen. The particular concrete mix included incinerator bottom ash (IBA) which is suspected of being the source of aluminium. Tests on raw materials and the mixed concrete revealed the presence of aluminium. Tests to confirm the suspected mechanism have not yet been completed.

In the meantime the supplier of the IBA has been asked to advise customers of the following:

- foamed concrete mixes containing IBA or other recycled materials should be poured in the open air
- if such mixes are to be poured within a building or confined area, adequate ventilation must be provided and the entire surface of the poured concrete should remain visible until it has set
- sources of ignition such as naked flames or spark-generating tools (eg disc cutters, angle grinders) should be kept away from the concreted area during the pouring and setting process.



Case Law

Council Not in Breach of PPE Regulations over Finger Injury

This case concerned an appeal against an earlier decision dismissing Mr Steven Threlfall's (the Claimant's) claim for damages for injury against the Defendant, Hull City Council. Mr Threlfall was injured whilst in the Council's employment. This issue, as regards this appeal, was whether or not, Judge Jack had reached the right conclusion originally, in ruling that the Claimant's injury had not been caused by a breach of the Personal Protective Equipment at Work Regulations 1992 (PPE Regulations).

Background

The Claimant was employed by the Defendant as a street scene operative. His work included clearing the gardens of council-owned properties of materials that had been dumped there. At the time of the accident, he was engaged (along with others) in clearing a garden that was overgrown and contained various items of rubbish, including at least one black plastic bin bag and its contents.

From the Claimant's accounts, the precise circumstances under which he suffered the injury are not entirely clear. Nevertheless, it is apparent that, in attempting to remove the bin liner, Mr Threlfall sustained an injury to the little finger of his left hand. The injury was of sufficient severity (the artery and nerve of the finger were severed and the tendon partially severed) that the Claimant had to undergo surgery.

He had received induction training as regards how to carry out his duties. He had also attended a one-day course on health and safety at work. Furthermore, his employer had provided him with various items of equipment, namely a litter picker, a rake, a shovel and a pair of gloves. The gloves were described as standard riggers' gloves. It is fair to say, on the basis of the evidence given, that the Claimant did not look down at the bag to ascertain exactly what it was, he was grabbing hold of. The issue, however, is whether or not the Defendant failed to provide suitable protective gloves.

Trial

There were two difficulties with the Claimant's contention concerning the Defendant's alleged failure in this respect. The first concerned his inability to say exactly how the injury had occurred and the second concerned his contention at trial, that he had only been provided with cloth gloves (that is, gloves containing no leather) and the inference, that had leather gloves been provided, the accident could have been avoided.

The Claimant was shown, on the day of the trial, a pair of standard riggers' gloves of the same type that he had been wearing when the accident occurred. Although comprised of a cloth back and sleeves, the gloves were also covered with leather on the palms and fingers. In view of this, the Claimant substituted his contention that the gloves were not sufficiently robust to one suggesting that they were unsuitable for the purpose for which they had been assigned and thus failed to satisfy the standards of regulation 4(1) of the PPE Regulations.

However, this contention was dismissed. The Judge concluded that, given the training and the equipment provided for him, the risk of the Claimant lacerating himself on a sharp object was very low. He also ruled that the gloves that had been supplied were adequate for the level of risk which existed, concluding that more than minimal force would be required to make even a sharp object penetrate the glove.



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Appeal

Regulation 4 of the PPE Regulations requires employers to ensure that suitable personal protective equipment (PPE) is provided to employees who might be exposed to a risk to their health and safety, except in circumstances where that risk has been mitigated (to an equal or better degree) by alternative means. It is also a requirement that any PPE provided should be appropriate for the risks involved and the conditions under which exposure to the risks is likely to occur.

In reaching his decision over the appeal, Mr Justice Blake concluded that the trial Judge had been correct in ruling that the Claimant had failed to establish that his injury had been caused by a breach of the PPE Regulations, on the basis that:

- it was unclear how the injury had occurred
- despite the injury, there was no evidence to indicate that a risk assessment revealed that the gloves were unsuitable.

One of the key pieces of evidence in informing this decision was the ruling from an earlier case (Rogers v George Blair (1971)) that, to be 'suitable', protection need not make it 'impossible' for an accident to happen, but must merely make it 'highly unlikely'.

Mr Justice Blake accepted the Defendant's submission that the Claimant had not been ordered to pick up objects which were identified specifically as being dangerous. Yes, there was a chance that, in the course of his garden clearance work, he might encounter sharp objects (whether apparent or partially hidden), but by use of the litter picker, spade and rake, he could avoid direct contact between the rubbish and his hands.

Furthermore, through common sense and the application of his basic training, the Claimant ought to have been on the look out for objects which might cause injury. Consequently, his appeal was dismissed.