

Prosecutions

Electrocution Incident – Company Fined

A farming company has been fined after a man was electrocuted while working on farmland near Ludgershall in Wiltshire.

Salisbury Crown Court heard Edward Pybus, 21, from Northallerton in Yorkshire, was harvesting crops at Chute Farm, Upper Chute when he received the fatal shock on 6 August 2007.

Farm managers Velcourt Ltd was prosecuted by the Health and Safety Executive (HSE) as the firm was responsible for both the recruitment of casual farm workers, including Mr Pybus, and for managing health and safety on site.

Velcourt Limited, of The Veldt House, Much Marcle, Ledbury, pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc Act 1974. It was fined £120,000 and ordered to pay costs of £45,000.

The combine harvester Mr Pybus was driving had a problem with the grain discharge spout and so it was left extended while he was cropping a field called Forest Lane Field. The field had 11,000 volt overhead power lines running across it.

During cropping the harvester had picked up stones and soil. Mr Pybus stopped the machine in order to clear it not realising the grain spout was touching one of the power lines.

As Mr Pybus got out of the harvester and stepped onto the ground, he received a fatal electric shock of 6,300 volts.

The HSE investigation found Velcourt Ltd failed to adequately inspect, monitor, supervise or audit health and safety management at the farm.

HSE discovered Velcourt had also failed to ensure the farm manager received adequate health and safety training. As a result, no risk assessments had been carried out at the farm for working in fields with overhead power lines, nor had the farm workers received adequate training on how to work safely.

No assessment

In addition, no assessment of the risks of operating the combine harvester model being used by Mr Pybus had been carried out. If one had, it would have found the machine's height with the chute extended (5.7 metres), exceeded the legal minimum height of overhead lines in fields (5.2 metres) and the actual height of the lines in Forest Lane Field (5.6 metres).

HSE inspector, Liam Osborne, said:

"Velcourt chose to give Edward one of the largest and tallest machines on the market on his first ever commercial harvest operating a combine. No consideration was given at all to whether it could reach the overhead lines in the fields where he was electrocuted, or anywhere else for that matter.

"HSE traced the root causes of this terrible incident to basic failures in Velcourt's safety management system. At no stage during the selection of their combines did Velcourt ask what the risk would be of touching overhead lines.

"Velcourt's farm contract manager was given inadequate safety training, particularly in identifying hazards, and what measures to take to reduce them. There was little to no review or monitoring of how well Velcourt were managing the substantial risks farmers face in the high-pressure work of harvesting.

"Had these basic, commonsense and entirely reasonable low-cost measures been put in place, Edward would still be here. We implore those who put their workers into hazardous jobs to think about the risks involved, then plan and control the work properly."

£10,000 Fine for Ride Owner

A fairground operator has been sentenced after an 11-year-old girl suffered a serious head wound when she was thrown from a ride at a Birmingham park.

Birmingham Magistrates' Court heard the girl was in a car on a ride, called DJ Jump, at the fair at Pype Hayes Park when the lap bar failed. She was also unable to put on the secondary safety measure, a lap belt, that may have prevented her being thrown from the ride.

During the HSE prosecution of fairground operator and owner of the DJ Jump ride, Robert Wilkinson, the Court heard the girl was thrown from the moving car and suffered a five centimetre head wound that required ten stitches. She also sustained numerous cuts and bruises.

The HSE investigation into the incident on 19 April 2009 found the lap belts in the ride cars were poorly maintained and most had been so badly damaged they were unusable.

Mr Wilkinson pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974 and was fined £10,000 and ordered to pay £2,708 costs.

Worker Trapped Beneath Stone Slabs

A granite business and one of its directors has been fined after a man was trapped under a two-and-a-half tonne pack of stone slabs while unloading a truck in Hillingdon.

The Health and Safety Executive (HSE) prosecuted M & R Granite & Marble Ltd and Monzer Mahmoud Alrayes, a director of the company, over the incident on 21 October 2010.

City of London Magistrates' heard the worker, who does not want to be named, was unloading pallets from an articulated truck under the direct supervision of Mr Alrayes, when a pack of stone slabs toppled and fell, trapping the man against another pallet.

Injuries to the man's chest and left arm required several operations and many months of post injury therapy and rehabilitation, which are likely to affect his future employment prospects.

HSE told the court M & R Granite & Marble Ltd failed to ensure the man was not exposed to the risk of falling stone slabs during handling operations.

After the hearing, HSE's Inspector Saif Deen said:

"The risks of handling stone slabs and loading or unloading operations from containerised lorries are well known as both the HSE and industry have highlighted.

"The incident was completely avoidable as many companies have developed methods of safely unloading containers and there is no reason why M & R Granite & Marble Ltd should be any different."

Mr Monzer Mahmoud Alrayes of 53 Lancaster Road, Northolt pleaded guilty to breaching section 3(1) of the Health and Safety at Work etc Act 1974. He was fined £5,000 and ordered to pay costs of £2,079.

M & R Granite and Marble Ltd of Unit 20, Brook Industrial Estate, Hayes, Hillingdon, pleaded guilty to breaching section 3(1) of the Health and Safety at Work etc Act 1974. The firm was fined £5,000 and ordered to pay costs of £2,079.

News

ISO Publishes new Nanotechnology Standard: Nanomaterial Risk Evaluation

ISO/TR 13121:2011 describes a process for identifying, evaluating, addressing, making decisions about, and communicating the potential risks of developing and using manufactured nanomaterials, in order to protect the health and safety of the public, consumers, workers and the environment.

ISO/TR 13121:2011 offers guidance on the information needed to make sound risk evaluations and risk management decisions, as well as how to manage in the face of incomplete or uncertain information by using reasonable assumptions and appropriate risk management practices.

Further, ISO/TR 13121:2011 includes methods to update assumptions, decisions, and practices as new information becomes available, and on how to communicate information and decisions to stakeholders.

ISO/TR 13121:2011 suggests methods organizations can use to be transparent and accountable in how they manage nanomaterials. It describes a process of organizing, documenting, and communicating what information organizations have about nanomaterials.

Guidance

Artificial Optical Radiation - Good Practice Guidance

Most workplaces contain artificial optical radiation sources. Directive 2006/25/EC lays down minimum health and safety requirements regarding exposure of workers to such sources. The European Commission's non-binding guide to good practice for implementing Directive 2006/25/EC pinpoints applications posing minimal risk and provides guidance on others. It sets out an assessment methodology and outlines measures to reduce hazards and check for adverse health effects.

Directive 2006/25/EC (the Directive) covers all artificial sources of optical radiation. Most of the requirements of the Directive are similar to existing requirements of, for example, the Framework Directive 89/391/EEC. Therefore, the Directive should place no greater burden on employers than is already required by other directives. However, since the Directive is so comprehensive, there is a need to identify applications of artificial optical radiation that are so insignificant with regard to health, that no further assessment is required.

This guide is intended to give an indication of such trivial applications, to provide guidance for a number of other specific applications, present an assessment methodology and also, in some cases, suggest that further assistance should be sought.

This guide should be read in conjunction with the Directive and the Framework Directive 89/391/EEC.

The Directive lays down the minimum safety requirements regarding the exposure of workers to risks arising from artificial optical radiation. Article 13 requires the Commission to draw up a practical guide to the Directive. The guide is primarily intended to assist employers, and in particular small and medium-sized enterprises. However, it may also be useful for employee representatives and regulatory authorities in Member States.

This guidance document is intended for all undertakings where workers may be exposed to artificial optical radiations. The Directive does not provide a definition for artificial optical radiations. Sources such as volcanic eruptions, the sun and reflected solar radiation from, for example, the moon, are clearly excluded. However, there may be a number of sources that are ambiguous.

The Directive does not specifically exclude any artificial optical radiation source. However, many sources, such as indicator lights on electrical equipment, will be trivial sources of optical radiation. This guide provides a list of sources that can be generically assessed as not likely to exceed the exposure limit values.

There will be some potential worker exposure scenarios which are complex and therefore beyond the scope of this guide. Employers should seek further advice on assessing complex exposure scenarios.

Working with Containers

This publication, issued by the Freight Transport Association (FTA), is intended to raise awareness amongst FTA members and other shippers and hauliers who may take on work requiring the use of maritime containers. Since the earliest days of 'containerisation' in the mid-1950s this concept of transporting freight has mushroomed into a global industry. All participants in supply chains worldwide, from owner/drivers with one vehicle to the largest fleet operators, to shippers and warehouse operators are likely to experience containers as drivers, loaders or handlers at some point.

As the cost of handling freight through the use of containers has fallen so an ever greater diversity of items shipped in this way has developed, along with a growing variety of specialist containers in which to transport them. However, a general purpose freight container is ideally suited to a huge range of items and it is this very flexibility which can lead to poor or non-existent freight restraint and result in a wide variety of incidents.

This brief guide aims to help members to discuss best practice when working with containers with their supply chain partners and thus make a contribution towards improving safety in the maritime container environment.

Experts in supply chains involving the use of containers are agreed that most problems can be grouped into two categories:

misdeclared containers, which may be overweight or underweight
the inadequately restrained goods inside them.

In January 2011, members of FTA's National Council concluded that ensuring proper weight distribution and load security within containers presented more challenges than weight issues. This guide highlights how different members in supply chains all have responsibilities to ensure their own safety and how their actions or lack of them can affect the safety of others.

Reports

RIDDOR Changes – CIEH Response

The CIEH has published a response to the outcome of the RIDDOR consultation, which concluded at the end of April.

The CIEH was supportive of the recommendations in the report "Common Sense, Common Safety" published in October 2010.

The logic of the recommendations made by Lord Young in the report 'Common Sense, Common Safety' – to extend the period for reporting injuries that lead to a worker being incapacitated for work, from three days to seven days – is acknowledged by the CIEH but the concerns of both regulators and businesses are recognised.

The CIEH believes that the acknowledged shortcomings of RIDDOR (such as the low compliance rate of 50%) will not be addressed by extending the period for reporting injuries and that a fresh and more comprehensive approach is needed to ensure businesses investigate and learn lessons from accidents and incidents.

The CIEH is not opposed in principle to the proposed extension of the reporting period but believes that it is an inadequate solution to securing better protection for workers and consumers.

The current system

The requirements of RIDDOR (the reporting of accidents for dangerous occurrences causing absences of more than three days) are not sufficiently observed (currently estimated at 50%) as to provide meaningful data.

The current system is often ineffective due to a lack understanding by businesses (and sometimes by regulators) as to the precise requirements of the regulations.

It does however lead to evidence based policy which is clearly a beneficial by-product. The investigation of accidents is integral to national strategy for protecting workers and consumers.

The proposed amendments

The CIEH believes that the extension of the reporting period to seven days will not contribute to worker or consumer safety, nor will it have a meaningful effect on reducing any perceived burdens on business.

One key omission is the lack of any reference to customer and public accidents. There is a need for greater clarity in dealing with such accidents which are an important issue for business.

It is generally considered that much of the under reporting is concentrated in the SME sector. Such businesses are in urgent need of clear guidance to improve the level of reporting and to address the fear of attracting unwanted "attention" from regulators resulting from reporting.

Extending reporting requirements from three to seven days is an isolated approach which focuses only on reducing burdens and does not address inconsistencies, says the response document.

The key issue for consideration should be the relative merits of fewer reports from more businesses compared with more reports from fewer businesses.

An alternative approach

The response document suggests a more straightforward system would be better understood by business, concentrating on medical intervention (eg accidents requiring visits to a GP or attendance at A&E).

Reporting could be linked to the Fit Note system; this could trigger investigations and would lead to better reporting. Such reporting would also facilitate intelligence led enforcement (and reporting).

Accidents requiring reporting to HSE could then be restricted to fatalities and notifiable major injuries and dangerous occurrences. The current list of dangerous occurrences has been in place for a long time, is difficult to understand and requires updating to reflect changes in businesses and practice. HSE would then be in a better position to gather meaningful data on the prevalence and causes of accidents (eg through periodic sample surveys by HSE).

Improving the Diagnostic Criteria for Work-related Upper Limb Disorders for Use in Prevention and Patient Care

The Health and Safety Executive (HSE) has published research on the optimal classification of musculoskeletal disorders affecting the upper limb (ULDs) in recognition that, to date, there has been no definitive diagnostic test for these conditions and, as a result, reliance has been placed on agreement by consensus.

Background

ULDs can be caused by, or exacerbated by work activities, with sufferers experiencing pain and discomfort which can result in time off work. The UK's Labour Force Survey (updated annually by the Office for National Statistics) calculates that 3.75 million working days are lost due to ULDs each year in Britain. Correctly identifying these conditions can help with the planning of appropriate clinical treatments and also facilitate the design and implementation of preventative measures in the workplace.

The HSE explains that the lack of clear diagnostic criteria for ULDs has made it more difficult to pool research findings on prevention and patient care, resulting in considerable variations in the treatment afforded sufferers. It has also made it harder to interpret literature on the subject, complicated by both the issue of compensation and case law, plus handicapped occupational health surveillance.

Main recommendations

This research suggests that:

- when evaluating any diagnostic classification scheme for ULDs it may be helpful to consider five criteria:
 1. feasible, unambiguous case definition
 2. face or content validity
 3. repeatability
 4. satisfactory measurement properties relative to an adequate gold standard (where there is one)
 5. utility, for example, in the identification of avoidable risk factors or beneficial treatments
- criteria one to three are partially satisfied by several diagnostic schemes but the fourth is virtually unachievable because of the lack of valid reference standards, whilst the fifth is often neglected. It may actually be of benefit to introduce a sixth criterion (covering severity/functional impact) to help in the assessment of the burden of disease and compensation due.

The researchers reviewed the performance of diagnostic classifications using the fifth criterion and considered case definition for purposes of prevention and treatment. They found that:

- different case definitions produced similar associations with putative risk factors
- data on associations with risk factors at a given anatomical site should be pooled when conducting systematic reviews, even if there are differences in case definition between studies
- simple case definitions are likely to be better than more complex ones in the case of health surveillance and workplace field studies - they are easier to implement and equally as effective at identifying risk factors, but at lower cost. This finding may encourage the gathering of larger datasets

- fundamental aetiological research may also benefit from simple case definitions – particularly where there is some level of doubt about mechanisms and the interplay of co-factors
- the limited evidence on optimal case definitions to support treatment decisions does not warrant an immediate change in clinical practice, given that no important differences in size of treatment response were found according to case definition. It is accepted that further research might highlight such differences
- some apparently effective treatments are selected on the basis of specific clinical features - for example lateral pain with tenderness is a good indication that a localised steroid injection will bring relief
- to help with the selection of treatment options, where possible, reports of treatment trial findings should incorporate secondary analyses for sub-groups of participants based on their medical condition at the start of the trial.

Conclusion

Establishing an optimal classification for ULDs proved difficult, particularly because of the absence of good reference standards: However, this research has identified that the current approach could be simplified, better harmonised and made both more rational, so as to improve the prognosis for ULD sufferers and help lower the incidence of these conditions.