



### Prosecutions

#### **£260,000 Fine in Fall Case**

A papermaking firm in Fife has been fined £260,000 after a worker fell almost 50 feet through a fragile roof to his death.

Thomas Sturrock, 32, from Methil, was working as part of a team for a contractor, cleaning the roof at Tullis Russell Papermaker Ltd's warehouse in Markinch, Fife, on 29 September 2008.

Kirkcaldy Sheriff Court heard that Mr Sturrock's co-workers on the roof heard a cracking sound before becoming aware that Mr Sturrock had fallen through the roof. Workers in the warehouse below also heard a loud noise and saw that Mr Sturrock had fallen through the roof to the concrete floor below.

An ambulance was called and paramedics pronounced Mr Sturrock dead at the scene. A post mortem examination established that Mr Sturrock would have died immediately following the fall.

A Health and Safety Executive (HSE) investigation found that when Tullis Russell Papermakers instructed the contractor to carry out the cleaning work, it failed to make sure the work was properly planned and organised, and when the contractor's employees were at work, they did not control, monitor and review the way the work was taking place.

The contractor had advised Tullis Russell Papermakers Limited the team would be using crawling boards on the fragile roof. However, such boards were not used and in order to carry out the cleaning work, workers accessed the roof by stepping onto it. Tullis Russell Papermakers Limited took no steps to check that crawling boards were in fact being used as agreed and failed to bring the unsafe work practices to a stop in spite of its internal procedures stating that work carried out by contractors should be monitored daily.

Tullis Russell Papermakers Ltd of Glenrothes, Fife, were fined £260,000 after pleading guilty to breaching section 3 of the Health and Safety at Work etc. Act 1974.

The case against the contractor remains under consideration by the Health and Safety Division of Crown Office and Procurator Fiscal Service.

Following the case, HSE Inspector Mac Young said:

"Thomas Sturrock might be alive today if simple safety measures had been put in place. If Tullis Russell had ensured the contractor's activities were monitored then it is possible the incident with Mr Sturrock may have been prevented.

"Tullis Russell Papermakers had a duty to ensure the safety of everyone on their site - whether working directly for them or not. Companies must make sure work contractors do for them is properly planned and organised, and monitor what actually happens when the work takes place."



### Care Home Fined over Fire Safety Breaches

The owners of a care home in Rochdale have been fined almost £5,000 after failing to provide adequate fire safety measures, including not conducting a sufficient fire risk assessment.

In April last year, Greater Manchester Fire and Rescue Service found a number of failings in the establishment's fire safety measures: including failing to keep emergency routes clear and not providing adequate fire escape route marking.

Earlier this month (February 3rd), Lily Care Ltd was fined £4,688 for the deficiencies, under the Regulatory Reform (Fire Safety) Order 2005.

Steve McGuirk, the county fire officer and chief executive of the service, said the role of the fire brigade is two-fold when it comes to preventative fire safety.

"We always support businesses that work to make their premises safe for people to use," he said.

"But we are also willing to take actions to protect the people of Greater Manchester where business owners and managers choose not to treat fire safety as a legitimate business requirement."

### Work Equipment Fine

An engineering firm has appeared in court after a worker was badly injured when his hand became entangled in an unguarded drill.

Michael O'Brien suffered permanent loss of movement to three fingers in his left hand following the incident at a construction site in Leyland on 1 December 2009.

The company, of Red Hall Court in Wakefield, was fined £4,000 and ordered to pay £3,250 towards the cost of the prosecution on 23 February 2011.

Jex Engineering Company Ltd was prosecuted by the Health and Safety Executive (HSE) for failing to ensure a guard was provided on the drill.

South Ribble Magistrates' Court in Leyland heard that he had been installing a machine in a new factory on Sustainability Way in Leyland when the incident happened. His hand got caught in the chuck, which holds the drill bit in place, while he was drilling holes into a steel plate.

The HSE investigation found the company failed to spot the guard was missing both when it hired the drill, and when it was issued to Mr O'Brien. It also wrongly indicated the drill had been fitted with a guard when it completed an assessment form for the work.

Jex Engineering Company Ltd pleaded guilty to breaching Regulation 11(1)(a) of the Provision and Use of Work Equipment Regulations 1998 by failing to prevent access to dangerous machine parts.

Allen Shute, the investigating inspector at HSE, said:

"These injuries have had a devastating impact on an engineer who relies on being able to use his hands for his job. Sadly, he has been unable to find work since the incident.

"Jex had three separate opportunities to make sure the drill was fitted with a guard but it failed to act on all three occasions.



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"Even small drills have the potential to cause serious injuries if they are not fitted with a guard. It's therefore vital that companies take the risk seriously."

### Security Firm Fined

A security safe manufacturer has been fined after an employee was burned while fitting an under-floor safe.

The Health and Safety Executive (HSE) prosecuted SMP Security Ltd, of Halesfield 24, Telford, following the incident in which Nigel Gibbon, 44, from Telford, was operating a flocking machine to apply a soft lining to the safe on 28 June 2008.

SMP Security failed to carry out a proper risk assessment for the work, meaning when Mr Gibbons used an adhesive to apply the nylon flock lining, a flammable atmosphere was created inside the safe. This then ignited when he operated the flocking machine, causing burn injuries.

Telford Magistrates' Court heard how Mr Gibbon suffered second degree burns to his left hand and wrist. He will require surgery to repair tendon damage to his hand and still suffers pain, particularly in cold weather.

SMP Security Ltd pleaded guilty to breaching Regulation 5(1) of the Dangerous Substances and Explosive Atmospheres Regulations 2002. The company was fined £2,000 and ordered to pay £6,000 costs.

HSE inspector David Kivlin said:

"Mr Gibbon would not have suffered these injuries if SMP Security had carried out a proper assessment of the risks arising from the flocking task.

"This would have identified several alternatives that could have been easily implemented such as using flocking equipment specifically designed for use in flammable atmospheres, or replacing the flammable adhesive with a water-based version.

"Had SMP taken the time to look at the risks, Mr Gibbon's injuries could have been avoided entirely. This wasn't the first time this type of incident had happened at the company, yet it failed to prevent it happening again."



### News

#### **Commission Requests the UK to Comply Fully with EU Legislation on Asbestos**

The European Commission has asked the UK to change provisions in its legislation that exempt some maintenance and repair activities from the application of the EU directive on protection of workers from asbestos. According to the Commission, UK authorities do not comply with three clear obligations, undermining the protection foreseen by EU law for workers exposed to asbestos. The request takes the form of a reasoned opinion under EU infringement procedures.

The UK now has two months to bring its legislation into line with EU law. Otherwise, the Commission may decide to refer the UK to the EU's Court of Justice.

The asbestos Directive 2009/148/EC lays down provisions to protect workers from asbestos related risks, mainly through preventive measures. Asbestos is a particularly dangerous agent, found for example in buildings. The inhalation of asbestos fibres can cause serious diseases, including cancer. The EU legislation applies to activities where workers are or may be exposed to dust arising from asbestos or materials containing asbestos at work.

The Commission received a complaint that Article 3(3) (a) and (b) of the asbestos Directive has not been correctly transposed in UK legislation. This Article 3(3) gives the possibility for an exemption from three obligations set out in the directive for activities that involve only sporadic and low intensity exposure to asbestos - like for example the case of some maintenance and repair activities.

These three obligations refer to notifying asbestos works to the responsible national authority; making a prior health assessment for the workers and a new assessment every three years, for as long as exposure continues; and keeping a register of the workers who are, or may be, exposed to asbestos at work.

In the Commission's view, the UK law omits certain specific parts of Article 3(3) (a) and (b) and so widens the scope of the derogation of this Article. The UK legislation currently focuses on the measurement of exposure to asbestos and not enough on how the material will be affected by the work itself, while the directive deals with both exposure and the material. This is why the Commission is sending a reasoned opinion to the UK authorities, requesting them to bring its legislation into line with EU law. The Commission may decide to refer the UK to the Court of Justice of the EU if action to ensure compliance is not taken.



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### HSE brings Crown Censure Process Against Defence Lab

An agency of the Ministry of Defence has been censured over safety failings that led to the death of a Government scientist.

On 21 February 2011, the Health and Safety Executive (HSE) completed a Crown Censure with the Defence Science and Technology Laboratory (Dstl) following an investigation into an incident on 14 August 2002.

Dstl employees, including Terry Jupp, were carrying out classified tests on explosive compounds at Shoeburyness, an establishment owned by MOD and operated by QinetiQ Ltd, when a mixture ignited. Chemist Mr Jupp, 43, from Hertfordshire, suffered 85% burns in the explosion and died a week later in hospital.

Dstl's Chief Executive, Dr Frances Saunders, attended the Crown Censure meeting on Friday 18 February and accepted the findings on behalf of the agency and the MOD.

By accepting the censure, Dstl has formally acknowledged there were health and safety failings, such as inadequate or poorly followed risk assessments when the possibility of explosion or ignition were clearly foreseeable. Mr Jupp and colleagues were not protected by a screen or personal protective equipment. Inadequacies were also highlighted in dynamic risk assessment and communication issues were shown to have impeded safety procedures.

Dstl is part of the MOD and as such cannot face prosecution from the Health and Safety Executive in the same way as non-Government bodies. Crown Censures are agreed procedures applicable to crown employers, including the MOD, in lieu of HSE criminal proceedings.

Crown Censure Chair, HSE's Susan MacKenzie said:

"Terry Jupp died needlessly. Even at the time of the incident, Dstl had well documented safety procedures, which, had they been followed fully, would have prevented or considerably reduced the severity of the incident.

"The evidence brought to light by the HSE's investigations would be sufficient to provide a realistic prospect of conviction of the MOD in civilian courts. This Crown Censure is the maximum enforcement action that the HSE can take and should serve to illustrate how seriously we take the failings that led to the death of Mr Jupp."

The HSE has taken this enforcement decision now after considering all evidence, including that from the August 2010 inquest into Mr Jupp's death. The Crown Censure proceedings relate to the discharge of duties as an employer, under Sections 2 and 3 of the Health and Safety at Work etc. Act 1974.

The initial investigation into Mr Jupp's death was led by the MOD Police acting in co-operation with the HSE in line with agreed national protocols regarding workplace fatalities. The Crown Prosecution Service brought gross negligence manslaughter charges against two Dstl managers but both cases were dismissed before a trial, one in 2005 and one in 2007.



### Framework for Process Safety Management

Following a number of recent incidents at offshore installations, refineries and petroleum storage facilities, effective process safety management is at the top of the agenda.

The Energy Institute (EI) has developed a common high level framework for process safety management across all energy industry sectors. The EI High Level Framework for Process Safety Management (PSM framework) provides a systematic approach suitable for all sizes of organisations, defining the key things organisations need to get right in order to assure the integrity of their operations incorporating technical, maintenance, operational, together with human and organisational factors.

The dramatic impact that safety incidents in the energy industry have had upon the share prices of the involved companies has caused some institutional investors to question the security of their investments in the high hazard industries.

This new publication will assist senior executives and managers to understand how well they are identifying and managing the significant risks within their organisations which, if not appropriately managed, could result in a major incident which may threaten people, environment, reputations, financial performance and the very future of their organisations.

### Sickness Absence Review

Prime Minister David Cameron has announced a review into sickness absence. Jointly chaired by David Frost, Director General of the British Chambers of Commerce and Dame Carol Black, National Director for Health and Work, the review will explore radical new ways on how the current system can be changed to help more people stay in work and reduce costs.

Reporting later this year, the review will:

- explore how the current sickness absence system could be changed to help people stay in work, reduce and share costs for the taxpayer and businesses, and contribute to economic growth
- examine whether the balance of these costs are appropriately shared between individuals, employers and the State
- make tangible recommendations for change
- ensure that recommendations for change are consistent with promoting private-sector growth and minimising burdens on business - in particular small and medium-sized businesses.

Under the current system, employers bear the costs of short term sickness with the State, and ultimately the taxpayer, absorbing the cost of longer-term ill-health, with over 300,000 people leaving work to claim sickness-related benefits each year - making up around half the total flow on to Employment and Support Allowance (ESA).

The review, which is jointly sponsored by the Department for Work and Pensions and the Department for Business Innovation and Skills, will include a panel of experts from business, trade unions and health representatives and will be conducted in the context of the Growth Agenda.

It will also feed into the wider Employment Law Review, which is looking at measures to reduce red tape and remove the burdens on business, encourage growth and maximise flexibility for employers and employees.

Also announced is an additional £12 million of funding for health and work programmes, including the Fit for Work Service and Occupational Health Advice lines. Both have already proved highly successful in providing support for both employers and individuals in the early stages of sickness absence.

## Guidance

### Complaints about Workplace Health and Safety

The HSE has updated this information. It advises that, anybody who considers that their employer (or someone else's) work activity is putting safety at risk or damaging health, then these concerns should be raised with that employer or person. If no improvement is made and the safety or health continues to be at risk, then you can report your complaint to the relevant enforcing authority and ask them to look into it.

In the first instance, the HSE can only take action on a complaint if:

- it relates to a work activity
- the HSE is the right enforcing authority for the work
- the issue complained about is sufficiently specific to enable identification of the issue and the dutyholder and/or location and that either:
- the issue complained about has caused or has potential to cause significant harm, or alleges the denial of basic employee welfare facilities, or
- it appears to constitute a significant breach of law for which the HSE is the enforcing authority.

Therefore, the HSE cannot deal with complaints about issues or employers where they do not have jurisdiction. Where such complaints are received by the HSE, no further action will be taken. Information included aims to help you identify whether the HSE is the correct enforcing authority.

*Is the HSE the correct enforcing authority for you?*

The HSE is responsible for enforcing health and safety at workplaces including:

- factories
- farms
- building sites
- nuclear installations
- mines
- schools and colleges
- fairgrounds
- gas, electricity and water systems
- hospitals and nursing homes
- central and local government premises
- offshore installations.

You should contact your local authority environmental health department if your complaint is about the following type of premises:

- offices (except government offices)
- shops
- hotels
- restaurants
- leisure premises
- nurseries and playgroups



- pubs and clubs
- museums (privately owned)
- places of worship
- sheltered accommodation and care homes.

Other enforcing authorities that cover specific areas are also set out, such as concerns about poor food hygiene should be raised with the Environmental Health Department; problems with goods and services you have bought should be raised with Trading Standards (Local Authority).

### **Guidance on the Preparation of an Application for Authorisation under REACH**

The European Chemicals Agency (ECHA) has published technical guidance on how to prepare an application for authorisation to use substances included in Annex XIV (List of substances subject to authorisation) under Regulation (EC) No 1907/2006 (the REACH Regulation). The document gives a general overview of the authorisation process, describes how to make such an application and how best to plan for substitution. It also provides guidance for third parties on submitting information on alternative substances or technologies.

#### *Target audience*

The guidance will be of particular use to manufacturers, importers and downstream users of substances that feature in Annex XIV of REACH. It may also be of interest to third parties who wish to contribute to the authorisation process.

#### *Background to authorisation*

REACH is the European Community Regulation on chemicals and their safe use and deals with the Registration Evaluation, Authorisation and Restriction of Chemical substances. It came into force on 1 June 2007 and is designed to streamline and improve the legislative framework on chemicals across the European Union (EU).

The REACH Regulation requires pre-authorisation of substances of very high concern (SVHC) before they can be used and placed on the market. The substances that fall with the scope of this requirement feature in Annex XIV of the Regulation. The authorisation process involves applying to the ECHA for permission to use substances included in Annex XIV and is designed to ensure that the risks associated with the use of the specified substances are adequately controlled, or alternatively, are out-weighted by their economic benefits. A fundamental feature of the authorisation procedure is the analysis of alternative substances or technologies which could potentially be used in place of an Annex XIV substance.

#### *The authorisation process*

The authorisation process involves a number of steps:

- applicant applies for authorisation (upon payment of a fee)
- application is publicised and interested parties have the opportunity to provide information on alternatives
- application is considered (with or without requests for further information)
- the relevant ECHA Committees prepare a draft opinion
- the applicant has a chance to comment
- the relevant ECHA Committees formulate their final opinion
- the final opinion is presented to the European Commission
- authorisation for a substance is, or is not, granted and the outcome is publicised



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- review of granted authorisations.

The preparation of an application for authorisation is expected to take between 12 and 24 months, depending on the applicant's experience of the process.

Certain key information must be included in an application for authorisation, namely:

- identity of substance(s) covered by the application
- name and contact details of the person(s) making the application
- request for authorisation(s) for specific use(s)
- provision of Chemical Safety Report(s) (CSR(s))
- an analysis of the alternatives
- a substitution plan.

Other information may be included:

- a socio-economic analysis (SEA) – a requirement where adequate control over risks to human health and the environment has not been demonstrated
- justification for not considering the risks to human health or environment - there are only two situations in which this exception would apply.

There is no tonnage limit for the authorisation requirement of SVHCs included in Annex XIV of REACH.

### *Conclusion*

This 141-page technical guidance offers potential REACH authorisation applicants clear advice, based on good practice, which both explains and facilitates the application process.



### Reports

#### **Buncefield: Why did it happen?**

Following the conclusion of criminal proceedings, the Health and Safety Executive (HSE) has published the findings of the four-year investigation by the Control of Major Accident Hazards (COMAH) Competent Authority Investigation Team into the underlying causes of the explosion and fire at the Buncefield oil storage depot in Hertfordshire on 11 December 2005. The report's conclusions identify the technical causes of the incident but also highlight significant management failings.

##### *The Buncefield oil storage depot*

The Buncefield oil storage depot is located in Hemel Hempstead and at the time of the explosion had hazardous planning consent to store 194,000 tonnes of hydrocarbon fuels – making it the fifth largest fuel distribution site in the UK. There were three sites operating from the depot - Hertfordshire Oil Storage Ltd (HOSL), British Pipeline Agency Ltd (BPA) and BP Oil UK Ltd. All three were classified as 'top-tier' sites under the COMAH Regulations 1999. The depot was served by three pipelines into the site and fuel arriving was segregated and stored according to its fuel type. Distribution from the site was either by road tanker or, in the case of aviation fuel, via a pipeline.

##### *Background to the incident*

Tank 912 was filling with petrol on the night of the incident but neither the gauge designed to enable employees to monitor the filling operation, or the independent high-level switch (IHLS) which was supposed to automatically halt the filling operations if the tank was overfilled were working – the former was stuck and the latter inoperable. Consequently, the tank overfilled, the petrol released formed a vapour cloud and this resulted in a massive explosion. The resultant fire lasted five days. The gauge had previously been reported as unreliable but had not received an adequate repair. The IHLS required a padlock to retain its check lever in a working position, but this was never fitted due to a failure in communication between the switch supplier and site personnel. Following the leak, reliance was placed on secondary (a bund retaining wall) and tertiary (a system of drains and catchment areas) systems of containment, all of which failed.

##### *Why did it happen?*

The investigation findings reveal that the Buncefield incident occurred because:

- process safety controls on safety critical operations were not maintained to the highest standards
- safety management systems failed to focus on major hazard risks, eg risk assessments did not consider the chance of more than one tank being on fire or take full account of the possibility that bunds could structurally fail
- bund failures were not treated as 'near misses', bund characteristics were not reviewed in light of updated standards/guidance and no one checked that their design and implementation (by contractors) was in accordance with good practice
- there was a lack of effective control by senior managers, with particular reference to fault logging, supervision of tank filling procedures, identifying unacceptable working pressures on staff and effectively supervising incoming fuels
- there was no standardised tank filling system
- leadership and top level engagement was found lacking in the handling of significant risks and the Board of HOSL failed to comply with its COMAH responsibilities
- auditing systems were ineffectual because they failed to test the quality of systems and nor did they ascertain whether they were actually being used, or were effective



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- designers, manufacturers, installers and those involved in the maintenance of equipment at Buncefield were not sufficiently knowledgeable about the environment in which equipment was to be used, as a result they were unclear regarding the standards to which they should work
- up to date drainage plans were not available and no advance contractual arrangements had been made for spill response teams to attend in the event of an accident
- there was little tertiary containment, with reliance placed on the site's normal drainage systems
- HOSL failed to effectively monitor the work of its contractors due largely to a lack of both expertise and resources. Contractual arrangements were poor and there was no formal 'management of change' process in respect to replacement of the IHLS switches
- the HOSL safety report did not properly assess how well it could prevent and if necessary, appropriately handle, a major accident
- process safety protection systems should not rely on operator response to alarms and overflow protection should be independent of normal operational monitoring
- bunds were, erroneously, not treated as safety-critical equipment. Although functioning as secondary containment, they were not impermeable or fire resistant and were unable to handle the large volume of firewater.

### *Conclusion*

Whilst technical failures caused the incident at Buncefield, the fact that they arose at all was the direct result of management failings - both in the lead up to the explosion and in its aftermath, where the mitigating actions were found to be inadequate. In addition, the design and maintenance of failsafe containment systems was also found to be lacking.

### **Asbestos Exposure and Smoking on the Risk of Lung Cancer Mortality for Asbestos Workers (1971-2005)**

The Great Britain Asbestos Survey was established in 1971 to monitor the long-term health of workers in the asbestos industry. Both asbestos exposure and cigarette smoking are recognised risk factors for lung cancer mortality. However, the exact nature of the interaction between the two is still debated. The objectives of the analysis undertaken for this HSE report were to:

- investigate if asbestos exposure increased lung cancer mortality risk in asbestos workers who have never smoked
- determine if the risk of lung cancer mortality reduces following smoking cessation for asbestos workers
- examine the interaction between exposure to asbestos and smoking on lung cancer mortality risk.

There were 1,878 deaths from lung cancer among 98,912 asbestos workers who were followed-up for a total of 1,780,233 person-years.

Over 50% of participants were smokers at the time of their last examination, with almost 45% of current and former smokers classed as heavy smokers (smoking more than 20 cigarettes a day). Both were higher than the percentage in the national population. Even after adjustment for smoking status, the mortality due to lung cancer for male asbestos workers was significantly higher than the national population.

Just 2% of lung cancer deaths occurred in asbestos workers who had never smoked. Overall, lung cancer mortality for never smokers who worked in the asbestos industry was higher than never smokers in the national population, but the difference was not statistically significant. Among never smokers, higher lung cancer mortality rates were seen for those first occupationally exposed to asbestos 30 to 39 years previously.

After adjustment for the smoking status of asbestos workers, the risk of lung cancer mortality increased with length of exposure and years since first occupational exposure to asbestos. Insulation workers had the greatest risk of lung cancer mortality, together with those first occupationally exposed to asbestos before 20 years of age.

Starting to smoke at an early age and high intensity smoking for long periods of time increased the risk of lung cancer mortality, after adjustment for the workers' asbestos exposure. Stopping smoking at any age resulted in lung cancer mortality rates that were lower than current smokers. Asbestos workers who quit smoking remained at an increased risk for lung cancer mortality up to 40 years after smoking cessation.

The interaction between asbestos exposure and smoking for asbestos workers was greater than additive, and the hypothesis that asbestos produces an effect proportional to the effect of smoking (multiplicative) could not be rejected. For those asbestos workers who smoked, an estimated 3% of lung cancer deaths were attributable to asbestos only, 66% to smoking only, and 28% to the interaction of asbestos and smoking.

Nearly 30% of lung cancer deaths among all male asbestos workers and 7% among the male national population were estimated to be attributable to asbestos exposure.

#### Recommendations

The report recommends that the Asbestos Survey should continue to recruit asbestos workers into the survey and monitor the long-term health of participants. This will allow assessment of the effectiveness of regulations implemented to reduce occupational exposure to asbestos on the risk of mortality among this high-risk group.

Asbestos workers who smoke should be actively encouraged to quit, thereby reducing the risk of lung cancer mortality.