Prosecutions

Waste Company Fined £250,000

A waste company has been fined £250,000 after a bin lorry ran over and killed a member of the public.

The Health and Safety Executive (HSE) prosecuted Team Waste (Southern) Ltd of Turners Hill, Sussex, after they were found to have breached health and safety laws which led to the death in Brighton.

Lewes Crown Court heard that on 5 March 2007, Anne Smith, 61, from Brighton, was hit by a refuse vehicle as it reversed up Cranbourne Street in Brighton city centre at 6.20am. The driver did not realise he had struck Mrs Smith until her body lay about three metres in front of the vehicle. Mrs Smith died shortly afterwards.

The HSE investigation found that the driver reversed the refuse collection vehicle without a banksman (known as a reversing assistant), contrary to Team Waste's operating policy. The vehicle also had defective CCTV at the rear and the audible reversing siren was turned off. The driver believed such alarms were prohibited before 7.00am.

Team Waste (Southern) Ltd failed to ensure that control measures identified in their own risk assessment were put into practice.

HSE's Inspector Sharon Humphrey said:

"Team Waste (Southern) Ltd failed to ensure the safe collection of rubbish. As a result of its failure an innocent woman has died unnecessarily. This has had devastating consequences for her family.

"Waste collection on public streets can be a high-risk activity if not properly planned. The law requires employers to assess the risks to its employees and members of the public.

"This incident could have been prevented had simple, low cost and readily available precautions been put in place. Detailed guidance, which is freely available from HSE outlines the requirements of the law and provides advice on the practical measures to take.

"The HSE takes failure to comply with these provisions seriously and will not hesitate to take action."

Team Waste (Southern) Ltd of Burleigh Oaks Farm East Street, Turners Hill, Crawley was found guilty of breaching section 3(1) of the Health and Safety at Work etc Act 1974. The company was fined a total of £250,000 and ordered to pay costs of £50,000.

Worker Ignored Safety Guidance

Safety signage is designed to protect workers from injuries in the workplace, and ignoring it could have serious repercussions, as Dewsbury Magistrates' Court heard recently.

A woodworker was found to be risking serious injury to himself and an employee after he ignored safety guidance and continued to use an unguarded saw.

Health and Safety Executive (HSE) inspectors issued two separate Prohibition Notices which were supposed to stop the worker using the saw until it was safe.

But while he complied with the first notice, after a guard on the machinery broke it wasn't replaced, and he was fined £4,000 with costs of over £1,300.

Neil Hope-Collins, a HSE inspector, said that the blade on the saw could have easily severed a limb had it slipped.

"The fact he used the saw unguarded after the initial enforcement action is extremely disappointing.

"Guarding is needed for a reason, and I hope today's prosecution sends a clear warning that we will take the strongest possible action against employers who operate dangerous equipment and machinery."

Electrician Sues Confectionery Giants

A Bracknell electrician is taking two of the country’s biggest confectionery companies to the High Court for the sum of £200,000, claiming their negligence led to him contracting asbestosis.

Charles Parker, 66, of Winscombe in Great Hollands, has issued a writ against Nestle and Mars, claiming the two companies are responsible for him getting the disease, which is caused by inhaling asbestos.

His writ, which was handed to the High Court on 14 April, claims he first came into contact with the deadly substance while working as an electrician and technician for Nestle between 1969 and 1971.

It claims he was regularly made to work in dust containing asbestos which he inhaled.

He worked at Mars’ now-closed factory in Liverpool Road, Slough, and its current office in Dundee Road between 1971 and 1999 when, the writ claims, he worked on pipes with asbestos.

He has developed asbestosis in both lungs and has pleural plaques in both lungs.

The condition has given him a 20% decrease in respiratory capacity that will worsen by 10 per cent every seven years.

He has an increased risk of premature death as well as other conditions such as lung cancer and mesotheolioma.

His writ accuses the companies of negligence and says they exposed him to a major risk of fatal injury without protection or warning, failed to give him breathing apparatus, failed to provide ventilation and failed to damp down dry asbestos.

The writ also accuses the two companies of employing him in work that constantly exposed him to risks without warning him, exposed him to a trap and a foreseeable risk of injury, and failing to provide a safe system of work and safe plant for his equipment.

Mr Parker said he first noticed shortness of breath and chest pain in 1995, but claims he was given contradictory medical advice and received a diagnosis only last February.

News

Catalogue of Errors Led to Rosepark Disaster

Fire precautions and training at a Lanarkshire nursing home where 14 elderly residents died in a blaze were 'systematically and seriously defective', according to the findings of a fatal accident inquiry.

None of the four night staff on duty at Rosepark Care Home in Uddingston when the blaze broke out in the early hours of 31 January 2004, had ever been on a fire drill, while owner Thomas Balmer failed to ensure that a "suitable and sufficient risk assessment" was carried out at the premises.

In his 1001-page determination on the tragedy, Sheriff Principal Brian Lockhart notes that 'some or all of the deaths' may have been avoided if the fire panel in reception had been labelled correctly. In fact, the zoning diagram that was supposed to help staff identify the location of a fire did not match the actual layout of the home's fire compartments. As a result, staff believed the fire was concentrated in the stairwell and lift shaft area of the lower ground floor, instead of the upstairs linen cupboard.

Mistakes during the home's construction in 1991 meant fire dampers were not fitted in the building's ventilation shafts, allowing smoke to travel through the building.

Sheriff Principal Lockhart said: "Instead of going to Corridor 4 where the fire actually was, staff investigated the foyer area and downstairs. In effect they investigated all parts of the building other than where the fire actually was."

Poor staff training also contributed to a nine-minute delay between the alarm sounding and the nurse in charge phoning the fire brigade.

"None of the staff on duty received any fire training. None of them had experience of a fire drill at Rosepark. None were given any training in the use of fire extinguishers. Isobel Queen, who was expected to be the nurse in charge that night and to take command of the situation, had been given no training in her role," said the Sheriff Principal.

However, Sheriff Principal Lockhart said it was the failure of owner Thomas Balmer to ensure that Rosepark underwent a 'suitable and sufficient' risk assessment that ultimately led to the tragedy. Although Mr Balmer had recruited health and safety consultant James Reid to inspect the home, no action was taken by the managers to follow through on his recommendations.

Nonetheless, Mr Reid's report was flawed, said the Sheriff Principal. "His document critically failed to identify the residents as persons at risk in the event of fire; it paid limited attention to the means of escape, the protection of the means of escape and the arrangements for evacuation."

The "worst-case scenario" of a fire breaking out at night was not covered.

Sheriff Principal Lockhart said: "The number of persons accommodated in Corridor 4, namely 14, were too many for an effective evacuation. This ought to have been obvious to a fire safety professional."

Mr Reid's report also failed to address dangers such as residents' bedroom doors being left open overnight, and the storage of aerosol canisters in an unsecured cupboard next to a "source of ignition" – a fuse box.

In addition, Mr Balmer did not ensure the home's electrical installations were ever checked in line with regulations from the Institute of Electrical Engineers (IEE), while documentation detailing an alleged arrangement between Rosepark and electrician Alexander Ross gave "a misleading impression of the arrangements in place at the home in respect of maintenance and inspection."

Sheriff Principal Lockhart said the fire started when an exposed wire touched the metal of the fuse box, releasing a spark.

If the system had been inspected and tested in accordance with the IEE regulations, the lack of insulation on the wire "would have been identified and rectified," said the Sheriff Principal. "In that event, the fire would not have occurred and the deaths might have been avoided."

He noted that in the period between the fire and the end of the 141-day inquiry there had already been "developments of a significant nature", which reduced the need for additional recommendations.

Rosepark has been fitted with a fire panel that automatically dials the fire brigade as soon as the alarm sounds, while swing-free closures have been fitted to bedrooms so that they shut whenever a smoke detector is set off.

There are also monthly fire drills, quarterly electrical inspections and all staff must take a fire warden's course.

However, the Sheriff Principal called for care home staff to have their duties more clearly explained, and urged Scottish ministers to formalise the relationship between the various regulatory bodies – the Fire and Rescue Authorities, the Health & Safety Executive, and SCSWIS (Social Care and Social Work Improvement Scotland), which took over from the Care Commission on 1 April – to prevent a repeat of the confusion by inspectors seen at Rosepark.

Brian Sweeney, chief officer of Strathclyde Fire and Rescue, said: "The nine-minute delay in calling us was crucial and the recommendations and observations of the sheriff regarding the Care Commission, the Health Board, the owners and the staff must now be the focus of attention."

A spokesman for NHS Lanarkshire, responsible for inspection until 2002, said: "We will need time to study [the Determination] to identify if there are any areas where we could improve practice for the NHS premises we are responsible for in Lanarkshire."

Guidance

Fire Safety Guidance for Purpose Built Blocks of Flats – Draft

Draft guidance on fire safety for purpose built blocks of flats has been published. Comments on the draft are invited by the LGA and should be received by 31 May 2011. The final guidance will be available at the end of July 2011.

The fire safety guidance for purpose built blocks of flats is sector owned guidance intended to give practical support and advice to all those with responsibilities for ensuring the safety of residents and others in these types of buildings.

It is relevant to private sector and social landlords, managing agents or facility managers, enforcement officers, advice agencies and those carrying out fire risk assessments.

Local Government Improvement and Development are leading the project to develop guidance on behalf of the sector, with funding from the Department of Communities and Local Government and the Electrical Safety Council. C.S. Todd and Associates Ltd were commissioned to draft the guidance and they have been directed by a Reference Group of key stakeholders including local authorities, private sector landlords, tenant and leaseholder organisations, housing and environmental health professions and the fire and rescue service.

Reports

Domestic carbon monoxide alarms

Carbon Monoxide (CO) is an invisible, odourless and tasteless gas produced by any fuel-burning appliance. Properly installed appliances are designed to combust fuel efficiently and produce little waste CO. Audible CO alarms can be used to detect when CO reaches levels which may be hazardous. For this HSE report, approximately 100 CO alarms, previously used by people in their homes, were tested and their use analysed. The key messages of the research are:

- sensors in CO alarms do not last forever – check the manufacturer's quoted lifetime for your CO alarm and replace it no later than recommended to ensure you continue to have adequate protection
- before purchasing a CO alarm, always ensure it complies with British Standard EN 50291 and carries a British or European approval mark, such as a Kitemark. Standards for the performance of CO alarms have become more stringent over recent years and so older alarms may not react as quickly as newer alarms. Check the manufacturer's recommendations about how you can test your alarm to ensure that the unit and the batteries are in good condition
- ensure that your CO alarm is correctly located – check the instructions from the manufacturer. Over 20% of alarms sampled were not fitted correctly, mainly due to being at the wrong height or not close enough to the potential source of CO
- audible carbon monoxide (CO) alarms are a useful back-up precaution, but they are not a substitute for the proper installation and maintenance of combustion heating appliances. Carbon monoxide can be generated by any combustion fuel and so it is important that all appliances are installed and maintained by competent engineers. For gas appliances by law this should be a Gas Safe registered engineer, for solid fuel appliances the approved body is HETAS, and for oil appliances the approved body is OFTEC.

Safe Use of Belt Conveyors in Mines

Belt conveyors have been used for a long time to transport minerals below ground in mines. This HSE report analyses data on belt conveyor accidents and dangerous occurrences for the five year period from 1986/87 to 1990/91. The report looks at how these accidents happened and makes recommendations on how to avoid them in the future. It is aimed at mine owners, mine managers, engineers, maintenance personnel, conveyor operators and conveyor users.

The report refers to an accident that occurred at Creswell Mine in 1950, which arose from the use of an underground belt conveyor. An outbreak of fire occurred when a hold-fast due to debris at a transfer point caused the rubber conveyor belting to ignite through friction. Although detected within minutes of starting, the fire spread some
555 m downwind along an intake roadway and 80 persons on the return side lost their lives as a result of carbon monoxide poisoning. Following this disaster, fire-resistant belting was developed and adopted by the National Coal Board (NCB) as the standard in all its mines, together with the requirement for systematic patrolling of conveyors; fire proofing of certain areas of roadways; improvements in fire-fighting training and in the 1960s the introduction of filter self-rescuers.

The purpose of this report is to examine and review the safety of belt conveyor operations and to recommend where safety could be improved. The accident and incident analysis in this report is based on the use of belt conveyors below ground in coal mines. The majority of the recommendations, however, are applicable to the use of belt conveyors both above and below ground and some are also applicable to conveyors used in other industries.