



SAFETY UPDATE

Issue 8 August 2017

THIS ISSUE

NEWS

HSE Work Related Figures

Construction deaths lowest

Asbestos related cancers

Major Contractors Alert system

Electrical Safety

CASES

Circular Saw use

Trapped in a running conveyor

Workman Burnt

Hand Arm Vibration

Workplace Manslaughter to Rise

Asbestos controls

Cross Rail Fined

Safe Systems not implemented

PUBLICATIONS

Sustainability by Reporting Practices

POSTER OF THE MONTH

Mindfulness

NEWS

HSE REPORTS CONSTRUCTION DEATHS AT RECORD LOW

Fatalities decline whilst asbestos related mesothelioma deaths rise

HSE has released the annual figures for work-related fatalities in 2016/2017 and the number of people known to have died from the mesothelioma (the asbestos-related cancer) in 2015.

The provisional annual data for work-related fatal injuries revealed that 137 workers were fatally injured between April 2016 and March 2017 (a rate of 0.43 per 100,000 workers), the second lowest year on record.

HSE report a long-term downward trend in the number of fatal injuries to workers. The number has halved over the last 20 years although in recent years the trend shows signs of levelling.

Construction deaths lowest number on record

The new figures show 30 fatal injuries to construction workers were recorded. This is the lowest number on record for the sector. The annual average for the past five years is 39. The annual average rate over the last five years in construction is around four times as high as the all industry rate.

This represents a 31% decrease in the number of construction fatalities. HSE has not published the fatal injury frequency rates for the construction sector (deaths per 100,000 workers) but the direction of travel usually follows the total number of deaths.

Asbestos related cancers

Mesothelioma contracted through past exposure to asbestos killed 2,542 in Great Britain in 2015 compared to 2,519 in 2014. The current figures relating to asbestos-related cancer reflect widespread exposures before 1980. Annual deaths are therefore expected to start to reduce after this current decade.

A full assessment of work related ill-health and injuries will be published by HSE in November 2017.

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MAJOR CONTRACTORS LAUNCH H&S ALERT SYSTEM

Build UK members share information for effective prevention of harm

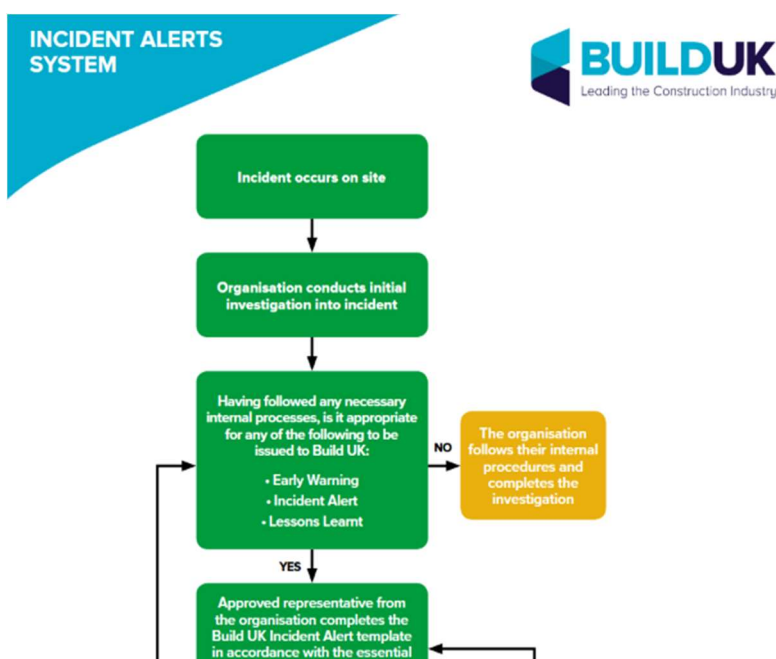
The *Build UK* has launched (July 2017) an Incident Alerts System designed to share information on serious incidents and accidents that have occurred on *Build UK* member sites. The aim is to prevent similar occurrences on other projects.

The system relates to three categories of incident alert:

Early Warning – Notice that an incident has occurred, but full details are subject to an investigation and not yet available (e.g. equipment failure and the consequences).

Incident Alert – Information on an incident that has occurred including any findings from an initial investigation (e.g. the reason why the equipment failed and subsequent actions taken).

Lessons Learnt – An update on a previously issued Incident Alert setting out any knowledge that has been gained from a full investigation into the incident. Where company procedures have been amended following the incident, these should be specified (e.g. leadership and supervision, attitudes and behaviors, and risk management).



The Incident Alerts will be anonymised prior being issued to *Build UK* to prevent any individuals involved being identified with personal data relating to any individual removed, redacted or deleted before the Incident Alert is issued to *Build UK*.

There is no requirement to automatically produce an Incident Alert following an incident on site and the system should not be “used for non-compliance with best practice or operational procedures”.

ELECTRICAL SAFETY: UPCOMING LEGISLATIVE CHANGES

2015 saw the introduction of Amendment 3 to the 17th edition of the Wiring Regulation, which brought with it new requirements covering consumers units, wiring in escape routes and protective devices, all designed to improve personal safety and quell the risk of domestic fires. The industry consensus was that the vital changes would be life-saving.

The 18th edition, which is due to be published in July 2018. One of the most significant reforms in the edition is likely to be around reducing the risk of fire. While Residual Current Devices (RCDs) are a vital safety tool in terms of reducing earth faults, they are not able to negate the risk of electrical fire caused by arcing between live conductors due to the fact that there is no leakage current to the earth. Further implications come in the case when the impedance of a series arc fault reduces the load current, keeping it below the tripping threshold of the circuit breaker. Therefore, it is expected that the reformed regulations will provide new guidance on the installation of arc fault detection devices (AFD) to mitigate the risk of fire in final circuits of a fixed installation due to the effect of arc fault currents.

The 18th edition is also understood to place a much greater onus on a risk assessment in order to determine if protection against transient overvoltage (e.g. lightning) is required for buildings to protect against the risk of fires and loss of supply. In addition, protection must be provided for high risk and sensitive locations, such as medical locations, heritage buildings, banks, IT centres etc.

A more extensive special locations section will provide greater clarity on electrical installations, such as embedded electric heating systems for de-icing or frost prevention in indoor and outdoor systems. These include heating systems for walls, ceilings, floors, roofs, drainpipes, gutters, pipes, stairs, roadways in areas such as football pitches, arenas and similar applications.

Following the launch of an initial draft for public consultation this summer, the 18th edition will be published in July 2018 and is due to come into effect for all new and rewired installations designed after January 2019.

CASES

TRAINING IN CIRCULAR SAW USE FOUND WANTING

Joinery firm failures end in serious hand injury and £230,000 fine

A joinery company has been fined £230,000 after the finger of an employee was severed at the company base in Rugby on 3rd February 2016.

Coventry Magistrates' Court heard how the 59-year old employee was using a circular saw to cut tapered strips of wood, when his hand met the saw blade.

The man lost the tip of his left thumb and the majority of his first finger because of the incident.

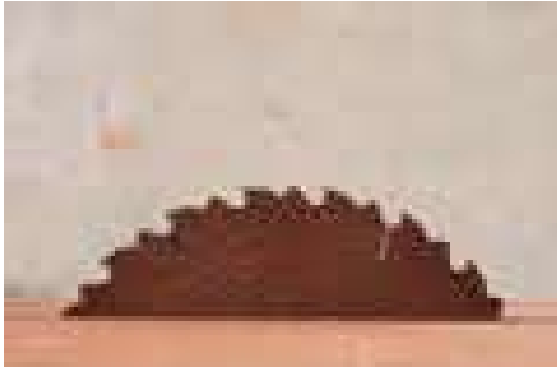
Supervision needed to oversee activity

HSE investigators found that the firm failed to provide the worker with the necessary training to carry out this work in a safe and appropriate manner.

The company pleaded guilty to breaching Regulation 9 (1) of the Provision and Use of Work Equipment Regulations 1998.

The company has been fined £230,000 and ordered to pay costs of £ 1779.70.

Speaking after the hearing HSE inspector Neil Ward said:



“There was a failure to check that workers had received the necessary refresher training to ensure they could safely operate the machinery.

This incident could have been prevented if the company had the required standard of supervision in place to oversee this activity.”

POWER FAILINGS AND INJURY END IN £1,900,000 FINE

Massive fine after workman suffers friction burns caused by conveyor

A major bread manufacturer has been fined almost £2m after an ‘agency’ worker was injured when his arm was trapped against a running conveyor belt in August 2015.

Nottingham Crown Court heard how worker was cleaning parts of the bread line when his arm was trapped causing friction burns which required skin grafts.

HSE investigators found CCTV footage showing the worker cleaning parts of the line. He reached into the line and became trapped between two conveyors. Part of the machine was dismantled to release the injured workman.

The court heard that localised guarding could have been installed to prevent access between the conveyors.

Safe equipment for employees and agency workers alike

The company from Nottingham, pleaded guilty to breaching Regulation 11 of the Provision and Use of Work Equipment Regulations 1998.

The company has been fined £1.9 million and ordered to pay full costs of £21,459.71.

Speaking after the case HSE inspector Edward Walker said:

“The company failed to guard the machine sufficiently to prevent access to the running conveyors, which in this case could have prevented the injuries.

Employers should ensure that all equipment used by agency and their own workers alike are sufficiently guarded and take appropriate measures if any deficiencies are found.”

WORKMAN BURNT CLEANING WITH FLAMMABLE LIQUIDS

Flammable substance and unprotected electrical equipment trigger flash fire

A paint manufacturer has been fined £80,000 after a worker suffered burns whilst cleaning the floor of a spray booth in November 2014.

Manchester Crown Court heard how the employee was using a highly flammable solvent to clean the floor of a spray booth. This was a task he had undertaken several times since the spray booth was installed.

HSE report that after complaints about how difficult it was to remove the dried paint the workman was “allowed to purchase” an industrial floor scrubber to carry out the task.

It was the electric motor on the floor scrubber which ignited the cloud of flammable vapour in the spray booth. The incident caused 26% burns to the workman who required treatment at a specialist hospital burns unit.

The employee had not been trained to clean floors and was not adequately supervised when carrying out the cleaning activity.

Custom and practice to clean with highly flammable solvents

The firm pleaded guilty to breaching Section 2 of the Health and Safety at Work Act 1974, and was fined £80,000 and ordered to pay costs of £39,669.40.

Speaking after the case HSE inspector David Myrtle said:



“This is a company that handles large quantities of flammable solvent, the hazards are well known and the company has a duty to control the risks arising from the hazards. It was custom and practice to clean floors using highly flammable solvents applied using a mop and bucket. In this instance, the company failed to adequately control the risks and an employee was seriously injured.”

VIBRATION UNCONTROLLED & WORKERS UNINFORMED

Engineering firm fined £120,000 over hand-arm vibration risk

A company has been fined for exposing employees using hand held vibrating power tools to the risk of developing hand-arm vibration syndrome (HAVS).

Manchester and Salford Magistrates heard how the company failed to ensure the risks to its employees from exposure was adequately controlled.

The company also failed to ensure its employees were given sufficient information, instruction and training on the effects of working with vibrating hand tools.

HSE investigators found that sometime near the end of 2015 a welder who had been working at the company for many years was allocated to a task which involved a significant amount of grinding and polishing.

After many hours undertaking this task the workman began to experience numbness and tingling in his hands. The workman asked to swap with another worker but was instructed to carry on the work. His symptoms continued but he was told by his supervisor to carry on using the vibrating tools.

Hand arm vibration is well-known risk

The firm pleaded guilty to breaching Regulations 6(1) and 8(1) of the Control of Vibration at Work Regulations 2005. The company has been fined £120,000 and ordered to pay £7,241 costs.

Speaking after the hearing HSE inspector Helen Jones said:

“This is a case of the company failing to protect workers using vibrating tools. Exposure to hand arm vibration is a well-known risk which the company failed to adequately control.

The company also failed to ensure workers were looked after when symptoms did arise leading to further exposure. This was wholly inadequate, and led to two employees suffering significant health effects.”

WORKPLACE MANSLAUGHTER OUTCOMES SET TO RISE

Guidelines target gross negligence with serious disregard and cost-cutting

The Sentencing Council has announced a consultation on its proposals for how offenders convicted of manslaughter should be sentenced in England and Wales.

It is the first time that comprehensive guidelines have been drawn up for these cases, which could include an unintended death resulting from an assault or a workplace fatality caused by an employer’s negligence.

The draft guidelines include gross negligence manslaughter where the offender is in breach of a duty of care towards the victim which causes the death of the victim and amounts to a criminal act or omission e.g. in a work setting to cover employers who completely disregard the safety of employees.

Sentencing
Council

Manslaughter Guideline Consultation

CONSULTATION

The proposals are based on an analysis of current sentencing practice, and in most areas, there are unlikely to be changes to sentence levels, but the Council expects that in some gross negligence cases, sentences will increase.

The Sentencing Council state that an example of where sentences may change could be “where a death was caused by an employer’s long-standing and serious disregard for the safety of employees which was motivated by cost-cutting”.

Current sentencing practice in these sorts of cases is lower in the context of overall sentence levels for manslaughter than for other types.

CONTRACTORS FAILED TO REVIEW ASBESTOS SURVEY

Major companies fined £1,000,000 plus over asbestos risk during refurb

Three companies have been fined a total of more than £1m after workers were exposed to asbestos while refurbishing a school in east London on 24 July 2012.

Southwark Crown Court heard that a worker removed part of a suspended ceiling in one of the ground floor refurbished rooms at St Mary's school and identified suspect asbestos containing materials. Asbestos fibres were subsequently found in numerous areas in the school.

Controls not suitable for potential exposure

HSE investigators found that although an asbestos survey was completed, there were multiple caveats and disclaimers which were not appropriately checked.

Company 1 - was fined £500,000 and ordered to pay costs of £32,364.84 after pleading guilty to breaching Section 2(1) and 3(1) of the Health and Safety at Work Act 1974.

Company 2 - was fined £370,000 and ordered to pay £32,364.84 in costs after pleading guilty to breaching Section 3(1) of the Health and Safety at Work Act 1974.

Company 3 - was fined £400,000 and ordered to pay costs of £175,000 after being found guilty after a trial of a breach of Section 2(1) of the Health and Safety at Work Act 1974.

Speaking after the hearing HSE inspector Sarah Robinson said:

“The principal contractor and contractors on site did not review the survey report in detail, and did not take into consideration the multitude of caveats.

Therefore, the work undertaken did not adopt the high standards of control expected for working where there was the potential to expose workers to asbestos.”



Managing and working with asbestos

Control of Asbestos Regulations 2012

Approved Code of Practice and guidance



L143 (Second edition)
Published 2013

This publication contains the Control of Asbestos Regulations 2012, the Approved Code of Practice (ACOP) and guidance text. Two ACOPs, L127 (*The management of asbestos in non-domestic premises*) and L143 (*Work with materials containing asbestos*) have been consolidated into this single revised ACOP. The presentation and language has been updated wherever possible. It provides guidance text for employers about work which disturbs, or is likely to disturb, asbestos, asbestos sampling and laboratory analysis. It also provides guidance on the specific duty to manage asbestos on the owners and/or those responsible for maintenance in non-domestic premises.

The Regulations set out your legal duties and the ACOP and guidance give practical advice on how to comply with those requirements. The Regulations give minimum standards for protecting employees from risks associated with exposure to asbestos.

The Regulations came into force on 6 April 2012, updating and replacing the previous 2006 law. They contain new requirements for certain types of non-licensable work with asbestos on notification of work; designating areas where you are working on asbestos; medical surveillance and record keeping.

CROSS RAIL JV CONTRACTORS FINED OVER FATALITY

Firm prosecuted after concrete fall death and two other tunnel incidents

A joint venture comprising three companies established to support the Crossrail tunnel construction project has been fined a total of more than £1m following three separate incidents on the project, including the death of a workman.

Southwark Crown Court heard that a workman died after he was crushed by falling wet concrete on 7 March 2014. Two other men were injured following separate incidents within six days of one another, on 16 and 22 January 2015. All three incidents took place in the tunnels around the Fisher Street area in London.

The deceased workman was working on a team enlarging the tunnel by removing rings of the existing pilot tunnel and spraying walls with liquid concrete. During this operation, a section of the roof collapsed causing fatal crushing injuries.

Lack of exclusion zones and plant maintenance

HSE investigators found a failure to provide a safe system of work relating to the operations involving two of the injured workmen. It was also found there was a failure to properly maintain the excavator involved in the third incident.

On all three occasions, the investigation found a failure to properly enforce exclusion zones that would have helped protect workers from foreseeable harm.

HSE Head of Operations Annette Hall said:



“The omission to implement exclusion zones in a high hazard environment was a consistent failure in this case. Had simple measures such as these been taken, all three incidents could have been prevented.

We believe every person should be healthy and safe at work. Here, all three workers were taking part in one of the most important and challenging infrastructure projects of the decade. It was this joint venture’s duty to protect its dedicated and highly-skilled workforce.”

SAFE SYSTEM DEvised BUT NOT IMPLEMENTED

Workman injured by goods falling from double-decked trailer A haulage company has been fined £100,000 after a load from the top of a double-decked trailer fell onto a workman below in February 2015.

Warwick Crown Court heard that an employee was injured at a site in Warwick, when metal ducting, some 6m long and weighing 28kg, fell from the top deck of the trailer.

The ducting struck his head and caused serious, life changing injuries, including a fractured skull.

HSE found that this work site had not implemented systems and procedures for unloading of trailers which had been produced by the company.

It was also discovered that employees were not properly informed about pedestrian and vehicle segregation rules, and little action taken in respect of the actions not being followed.

Measures easily implemented

The company from Irvine, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and have been fined £100,000 and ordered to pay costs of £53,401.

Speaking after the case HSE Inspector Mark Austin said:

“This incident could so easily have been avoided by simply implementing suitable control measures and safe working practices.

The company itself had identified and easily implemented the necessary measures after this tragic event.

PUBLICATIONS

The Need for Standardized Sustainability Reporting Practices

<https://www.iosh.co.uk/~media/Documents/News/Need%20For%20Sustainability%20Reporting-Final-August.pdf?la=en>

According to IOSH, this study into corporate reporting practices for occupational illnesses, injuries and fatalities demonstrates continued weakness and the need to improve reporting.

Access and scaffolding guides now open to members and non-members

The *National Access and Scaffolding Confederation* (NASC) health & safety and technical guidance titles are all now available to download free of charge from the NASC website. The only titles still requiring purchase are the pocket guides and the TG20 suite of publications.

The NASC publishes a comprehensive and expanding range of industry guidance titles which are regularly reviewed and updated by the NASC Health & Safety and Technical Committees.

https://www.nasc.org.uk/shop/?swoof=1&product_cat=health-and-safety-guidance

Industry Plant Safety Group highlights hazards and key control measures

The Strategic Forum Plant Safety Group (SFPSG) has released a new publication on plant safety entitled – *Reducing Unintended Movement of Plant – Managing Exposure to Consequential Risks*.

Unintended movement of plant machinery occurs when inadvertent operation of a control such as a switch, lever or pedal occurs, causing unintended machine movement which can potentially cause serious injuries and fatalities.

The new publication, which has been developed in conjunction with HSE provides guidance on a range of control measures to help prevent this from happening.

<https://www.cpa.uk.net/sfpsgpublications/>

