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HEALTH & SAFETY CASES

2020 Cases

Health and Safety Executive v Viridor Waste Management Ltd (2020) Folkestone magistrates' court, March 3

Statutory reference: regulation 4 of the Workplace (Health and Safety and Welfare) Regulations 1992 (WHSWR)

Viridor Waste Management Ltd, a waste management company, has been fined following an incident in which a worker suffered serious injuries.

- In February 2017 an employee of the company was working as a banksman at its site in Crayford.
- He was assisting a lorry to manoeuvre into a bay when a shovel loader reversed out of the bay.
- The vehicle struck the worker and drove over the lower half of his body. He suffered multiple fractures and internal injuries with life-changing effects.
- The company had failed to organise the workplace in such a way that pedestrians and vehicles could safely circulate.
- The prosecution was the fourth in four years for the company.

Decision

The company was fined £400,000 under regulation 4 of WHSWR.

Health and Safety Executive v Metalart Fabrication Ltd (2020) Westminster magistrates' court, March 4

Statutory reference: s.6 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Metalart Fabrication Ltd, a manufacturer of bespoke gates, has been fined after a child was crushed by a steel gate.

- In May 2018 an eight-year old girl was leaving an evening class at a school in Streatham. A sliding gate fell on her, causing multiple fractures and internal injuries.
- The gate, measuring five metres long and 1.7 metres high, was installed at the school by Metalart.
- The mechanism for preventing the gate from falling was insufficient if the gate was opened robustly.
- When the girl opened the gate it became disengaged from the rollers holding it up and fell on her.
- The company modified the gate's stop mechanism on the day after the incident.

Decision

The company was fined £19,000 under s.6 of HSWA.

An HSE inspector commented after the case that the failure to fit suitable end-stops to the gate meant that it was an accident waiting to happen.

Crown Office and Procurator Fiscal Service v Tayside Health Board (2020) Perth Sheriff Court, March 19

Statutory reference: s.3 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Tayside Health Board has been fined after three deaths in a hospital.

- Between April 2012 and November 2015, on the psychiatric ward of Murray Royal Hospital in Perth, three patients took their own lives using ligature points.
- Tayside Health Board had failed to assess, manage and control the risk of serious injury and death associated with ligature points.
- Private rooms within the ward had multiple ligature points which could have been removed to reduce the risks.
- The Board had failed to effectively communicate risks of ligature points to workers who monitored and assessed patients.
- A previous attempt by a patient to secure a ligature was not communicated to staff who monitored her, and the patent later took her own life, using the same method.

Decision

The Board was fined £120,000 under s.3 of HSWA.

Death of customer

Health and Safety Executive v Michael Douglas Autosalvage Ltd (2020) Carlisle Crown Court, January 17

Statutory reference: s.3 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Michael Douglas Autosalvage Ltd has been fined following the death of a customer.

In February 2018 a lift truck, which a customer had purchased from the company, was being loaded onto a recovery vehicle. The metal ring on the lift truck to which a winch wire was attached failed. The lift truck fell on the customer, causing fatal injuries.

The company had failed to ensure that the complex lifting process was properly planned by a competent person. It had failed in its duty not to expose customers to risk.

A competent person would have identified that the loading method which caused the accident was fundamentally unsafe.

Decision

The company was fined £23,000 plus £8000 costs under s.3 of HSWA.

Death of worker

Health and Safety Executive v Chesterfield Special Cylinders Ltd (2020) Sheffield Crown Court, January 13

Statutory reference: s.2 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Chesterfield Special Cylinders Ltd has been fined following an incident in which a worker was killed.

In June 2015 an employee of the company was leak testing a number of large cylinders by applying compressed air to create pressure. The test manifold failed and ejected shrapnel which struck the worker, causing fatal injuries.

A quantity of mineral-oil based corrosion inhibitor had been placed in each cylinder. This contaminated the test manifold and ignited, causing the test equipment to fail.

Decision

The company was fined £700,000 plus £169,000 costs under s.2 of HSWA.

An HSE inspector is reported to have commented after the case that companies must accurately identify and control all potential hazards in the workplace and monitor performance through effective supervision

Unregistered gas work

Prison sentence

Health and Safety Executive v Richard Goldthorpe (2020) Manchester Crown Court, February 10

Statutory reference: s. 3 of the Health and Safety at Work, etc., Act 1974 (HSWA) and regulation 3 of the Gas Safety (Installation and Use) Regulations 1998 (GSIUR)

Richard Goldthorpe, a gas fitter, has been sentenced to imprisonment for working on gas appliances while unregistered.

In November 2014 the HSE served a prohibition notice on Goldthorpe preventing him from carrying out gas work unless he was registered with the Gas Safe Register. Between March 2018 and March 2019 Goldthorpe worked on gas appliances at seven addresses.

A number of defects were found on all the appliances. These included incomplete and defective flue joints, flues not sealed to building structures and the dangerous decommissioning of a boiler. All the defects posed risks to safety.

While on bail awaiting sentence, Goldthorpe undertook further gas work while unregistered.

Decision

Goldthorpe was sentenced to 16 months imprisonment for seven offences under s.3 of HSWA and two offences under regulation 3 of GSIUR.

An HSE inspector commented after the hearing that Goldthorpe had knowingly defrauded homeowners and purposely misled them into thinking that he was registered with Gas Safe Register.

Work-related upper limb disorders

Measure of damages

Welsh v Trufab Ltd [2019] 9 WLUK 483, Manchester county court

W, a male aged 19 at the start of the injury period and aged 36 at the date of the hearing, suffered carpal tunnel syndrome while being employed by T. He was employed as a polisher and fabricator of metal products. He sought compensation from T under the Manual Handling Operations Regulations 1992 and the Control of Vibration at Work Regulations 2005, for exposing him to injurious levels of vibration and forceful manipulation of his upper limbs. He suffered numbness of his hands, pain and tingling. He was advised to undergo release surgery. He suffered a disadvantage on the labour market and loss of earnings.

Award:

£10,000 general damages; Smith v Manchester award £5000; future surgery costs £4000; Simmons v Castle 10 per cent uplift.

2019 Cases

Health and Safety Executive v Clancy Docwra Ltd and Daniel Walsh (2019) Southwark Crown Court, August 2

Statutory reference: ss. 2, 3 and 7 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Clancy Docwra Ltd, a construction company, and one of its employees, have been sentenced following the death of a worker.

- In March 2014 Kevin Campbell, a site operative working at night on a construction site was struck by an excavator mounted vibrator. He had been disconnecting lifting accessories from a metal pile which had been extracted from the ground. He was crushed against a concrete wall and suffered fatal injuries.
- Clancy Dowra, the principal contractor for the site, had failed to ensure, so far as was reasonably practicable, the safety of its employees and others who were not its employees.
- Daniel Walsh, the site supervisor, who was operating the excavator at the time of the incident, failed to take reasonable care for other persons on site.

Decision

- The company was fined £1,000,000 plus £108,000 costs under ss. 2 and 3 of HSWA.
- Walsh was sentenced to six months imprisonment, suspended for 12 months, and was ordered to pay £15,000 costs.

An HSE inspector commented after the case that informing all operatives of specific risks and the control measures required in relation to exclusion zones, the importance of communication and the mandatory use of excavator safety levers should have been put in place.

Health and Safety Executive v Bradfabs Ltd (2019) Leeds Crown Court, July 26

Statutory reference: s.3 of the Health and Safety at Work, etc., Act 1974 (HSWA)

Bradfabs Ltd, an electric gate company, has been fined following the death of a child caused by a falling gate.

- In October 2015 a six-year old boy was playing with friends on the electric gate of an underground car park in Leeds. They were pushing the gate open and closed.
- The gate was pushed beyond its retaining mechanism because no endstop had been fitted to the gate track. The gate fell onto the child, causing fatal injuries.
- Bradfabs, the company which had installed the gate, failed to install an endstop. No-one involved in maintaining the gate had noticed or rectified the omission.

Decision

The company was fined £30,000 plus £12,000 costs under s.3 of HSWA.

Health and Safety Executive v Celtic Rock Services Ltd and Alwyn Griffith Hughes Thomas (2019) Plymouth magistrates' court, August 1

Statutory reference s.2 of the Health and Safety at Work, etc. Act 1974 (HSWA)

Celtic Rock Services Ltd, a company which provides specialised services in rock drilling, cliff stabilisation and rock anchors, and its director, have been sentenced following a number of workers being diagnosed with hand arm vibration syndrome (HAVS).

- Employees of the company used rock drills and jack hammers for cliff stabilisation work while abseiling down a cliff and using the tools horizontally. They experienced symptoms including pins and needles and aching hands. HAVS was identified in 2016.
- The relevant risk assessment did not identify actual exposure to vibration and had used out of date vibration data.
- There was no health surveillance in place until 2016 and employees were not made aware of HAVS and its symptoms. When symptoms were reported, the company failed to take action.

Decision

The company was fined £36,667 plus £3500 costs under s.2 of HSWA.

Alwyn Griffith Hughes Thomas, the director of the company, was sentenced to 12 weeks imprisonment suspended for one year, a twelve-week curfew and ordered to pay costs of £3500.

Health and Safety Executive v NPS Worldwide UK Ltd (2019) Manchester magistrates' court, August 1

Statutory reference: ss. 2 and 3 of the Health and Safety at Work, etc., Act 1974 (HSWA) and regulation 3 of the Health and Safety (First Aid) Regulations 1981 (HSFAR).

NPS Worldwide UK Ltd, a company which manufactures absorbent products, has been fined following an incident in which a worker suffered hand injuries.

- In October 2017 a female agency worker was working at the company's site in Oldham. She was removing a blockage in a filling machine when her fingers became caught in an unguarded rotating fan.
- She lost parts of all her fingers on her right hand, sustained extensive scarring to her stomach following an unsuccessful skin graft and continues to suffer post-traumatic stress disorder.
- The fan had not been suitably guarded.
- The company had failed to carry out a suitable risk assessment and to provide adequate information, instruction and training to workers.
- No first aid provision was available when the incident happened. This contributed to the worker's suffering because incorrect first aid was administered.

Decision

The company was fined £28,000 plus £7700 costs under ss. 2 and 3 of HSWA and regulation 3 of HSFAR.

Fire

Post-traumatic stress disorder

Dow v Amec Group Ltd [2017] CSIH 75, Scottish Inner House

D was working on the roof of a unit at a power station. A fire broke out in the unit and D was trapped for 15 minutes. He alleged that there had only been one exit from the roof and that he had not been able to reach it because of smoke. He claimed that he had suffered chronic post-traumatic stress disorder and that his employers had been in breach of the Fire (Scotland) Act 2005 and the Construction (Design and Management) Regulations 2007. At first instance the claim was rejected. The court found that there had been more than one escape route and that D had not identified any failures or breach of obligations on the part of the employer. D appealed to the Scottish Inner House.

Decision

1. The appeal was dismissed.

2. Any breach by the employer had not been a direct cause of D's injury.

3. D had failed to identify any fire safety measure which would have prevented him suffering harm.

4. The employer had done what was reasonably practicable. There had been more than one escape route.

5. The fact that in the circumstances of an emergency the routes had not proved sufficient and suitable did not amount to a breach of the statute or regulations.

Manual handling

Burden of proof

Sloan v The Governors of Rastrick High School [2015] PIQR P1, Court of Appeal

S was employed by G as a learning support assistant. Her work involved pushing students who used wheelchairs between classrooms and other parts of the school. After pushing one student she experienced pain in her shoulder and back. Her GP prescribed pain relief and muscle relaxants. She returned to work and was not required to push wheelchairs. She left her employment and claimed compensation under the Manual Handling Regulations 1992, as follows;

1. The employer had failed to avoid the need for her to undertake a manual handling operation which involved a risk of injury;

2. Failure to make any suitable and sufficient assessment of such manual handling operations;

3. Failure to take any or any appropriate steps to reduce the risk of injury arising out of such operations to the lowest level reasonably practicable.

At first instance, the claim was dismissed. S appealed to the Court of Appeal. That court dismissed the appeal and made the following points:

1. Although the trial judge had misdirected herself as to the burden of proof, which lay on the employer, that misdirection had not undermined the judge's findings and conclusions. These were made on the evidence as a whole. The judge's findings were not influenced by any question of the burden of proof.
2. It was clearly correct on the evidence for the judge to find that it was not reasonably practicable to avoid the use of manual wheelchairs in the school. Annual risk assessments were made for each student who needed to use a wheelchair.
3. It was nit-picking to criticise the judge for stating only that the risk assessment was suitable and failing to say that it was sufficient.
4. The evidence amply justified the conclusion that the risk assessments were prepared by a suitably qualified and experienced individual.
5. There had been full and adequate training for S. The evidence fully justified the judge's conclusion that the school had taken appropriate steps to reduce the risk of injury to the lowest level reasonably appropriate.

Negligence

Vicarious liability

Christmas party disco

Shelbourne v Cancer Research UK [2019] EWHC 842, High Court

A Christmas party was held by CR at a Cambridge University research institute. It was organised by an employee and run by staff members. It was a ticket-only event and included a disco. Alcohol was available. A risk assessment was carried out before the event. B, a partygoer, was a visiting scientist who was not employed by CR but was working under its supervision. Having drunk alcohol, B approached three women at the disco and lifted them from the ground. When he lifted S, he dropped her and she suffered a serious back injury.

S alleged that CR was liable either because of its own negligence or because it was vicariously liable for B's actions. Given the availability of alcohol, CR should have conducted a risk assessment covering all eventualities stemming from inappropriate behaviour, provided trained staff to look out for trouble and required all partygoers to make a written declaration that they would not behave inappropriately. At first instance S's claim was dismissed on the basis that CR had not breached its duty of care and was not vicariously liable because B's conduct had been outside the field of activities entrusted to him as a visiting scientist. S appealed to the High Court.

Decision

1. The appeal was dismissed.

2. The requirements put forward by S were such that a reasonable person would not regard them as socially appropriate to impose on the organisers of a Christmas party. CR had carried out a risk assessment which took into account the fact that alcohol was available and it had not been necessary to address what an inebriated person might have done on the dance floor. The suggestion that a social gathering could only be appropriately monitored by detached observers set the standard of care unreasonably high.

3. B's field of activities was his laboratory work. This was not sufficiently connected with his conduct on the dance floor to make CR vicariously liable. He had not been required to attend the party.

Noise

Breach of statutory duty

Royal Opera House Covent Garden v Goldscheider [2019] EWCA Civ 711, Court of Appeal

G, a viola player in ROH's orchestra, suffered injury to his hearing which ended his professional career. He had been playing in Wagner's ring cycle, directly in front of the brass section. He was wearing 28 db earplugs. The noise from the brass section was recorded at 91 db. ROH was aware of its duties under the Control of Noise at Work Regulations 2005 and had provided earplugs. This made it difficult to hear other players and the musicians had been told to wear them at their discretion. At first instance, ROH was found liable for breach of statutory duty. It appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. ROH had not reduced noise exposure to as low a level as was reasonably practicable,

3. There was no evidence that nothing more could have been done to reduce noise without abandoning the Wagner ring cycle.

4. The 2005 regulations had been enacted to protect employees from excessive noise at work. It was foreseeable that if the occupational exposure limit was exceeded by a factor of four, musicians would suffer injury to their hearing.

5. The orchestra pit should have been designated a hearing protection zone and an appropriate sign should have been displayed.

6. G had established the risk of excessive exposure to noise inherent in the activity which he was carrying out.

Occupational stress

Procedure

Malone v Lord Advocate [2018] CSOH 86, Scottish Outer House

M was employed by the Crown Office and Procurator Fiscal Service for 20 years. She was dismissed in 2014. She suffered an episode of stress in 2001 which was resolved by her transfer into a different role. In 2010 she sought a further transfer because she was concerned that the workload and culture were adversely affecting her health. In 2013 she absented herself from work. She stated that she had made repeated complaints about unsustainable workload and inadequate staffing levels. From April 2012 she had been suffering from a recurrent depressive disorder brought on by intolerable working conditions. She argued that the employer knew or ought to have known that she was suffering stress at work which was a risk to her mental health and should have taken steps to support her. Further, she should have been given an individual risk assessment which would have disclosed her problems. If the employer had implemented those steps before 2013 it would have reduced or avoided the stress on her and would have enabled her to remain in employment. For the employer, it was argued that there was no basis in which the court could be satisfied that it was reasonably foreseeable that M was at risk of psychiatric harm.

Decision

1. The case could proceed.

2. It was not a case which was bound to fail.

3. The pleadings were sufficient to allow the case to proceed.

Prison sentence

Crown Office and Procurator Fiscal Service v Harvey (2019) Hamilton Sheriff Court, October 16

In May 2016 a worker employed by Front Row Builders Ltd suffered fatal crush injuries when he was pinned against a wall by an excavator bucket. Robert Harvey, the sole director of the company, was operating the excavator to lower cement and blocks into an excavation at a construction site. He had failed to carry out a sufficient risk assessment and operated a long reach excavator without the appropriate training or certification.

Decision

Harvey was sentenced to 10 months imprisonment under section 7 of the Health and Safety at Work, etc., Act 1974.

Risk assessment

Manual handling

Lifting heavy equipment

Dehenes v T Bourne and Son 2019 Scots Law Times 219, Sheriff Court

D, a driver and porter, claimed compensation from TB, his removal company employer, for injuries suffered as he was manoeuvring heavy machinery. He had been instructed to move analysing machines, each of which weighed 250kg, to Heathrow airport. D and three workmates, one of whom was a team leader, loaded each machine manually onto a pallet. D was walking backwards, holding a corner of a machine, when he tripped over a pallet. He let go of the machine, which fell onto his hand. He claimed that TB had breached its common law duty to take reasonable care, was vicariously liable for the team leader's failure to carry out a suitable and sufficient risk assessment and that manual handling could have been avoided by the use of a hydraulic lift.

Decision

1. TB was liable.

2. D was a credible and reliable witness who had proved that the incident happened as he described.

3. The relevant risk assessment was superficial.

4. The use of a hydraulic lift would have reduced manual handling to the lowest level reasonably practicable.

5. It was not possible for D to rely on a direct breach of the Manual Handling Operations Regulations 1992 because of the Enterprise and Regulatory Reform Act 2013. However, it was still relevant to consider TB's obligations under the 1992 Regulations in considering the scope and standard of care of duty owed.

6. The manual handling operation in the present case plainly involved a foreseeable risk of injury. The risk assessment was neither suitable nor sufficient and TB had not taken reasonable care for D's safety.

7. There was no contributory negligence. The reality was that D had been placed in a very difficult position and had been fearful of losing his job if he did not continue.

8. Compensation of £28,500 was awarded.

Work at height

Sentencing

R v Electricity North West Ltd [2018] EWCA Crim 1944, Court of Appeal

ENW owned, operated and maintained the electricity distribution network in the northwest of England. It had a generic risk assessment which prescribed three methods of accessing wooden poles which supported overhead electrical wires. The methods were a mobile elevated work platform, a ladder, and climbing with climbing irons, a work positioning belt and a fall arrest lanyard. An employee of ENW carried out pole maintenance work. A mobile elevated work platform was not available. The worker used a ladder to climb a pole and secured himself with a belt. He accidentally cut through the belt, fell and suffered fatal injuries. The company was charged with the following offences:

- Failure to carry out a suitable and sufficient risk assessment
- Failure to ensure that work at height was properly planned
- Failure to ensure the health and safety of employees.

The jury acquitted on counts one and three and convicted of count two (work at height). The judge at first instance applied the sentencing guidelines on the basis that the need to plan for work at height was obvious and a systemic failure put the case in the category of high culpability. He started at a fine of £540,000, adjusted upwards to £900,000 to reflect the company's turnover. The company appealed against conviction and sentence.

Decision

1. The appeal against conviction was dismissed and the appeal against sentence allowed.

2. The fact that a risk was not reasonably foreseeable was not a defence to a breach of the work at height regulations by a failure of proper planning, which was a strict requirement due to the inherent danger of working at height.

3. The verdict had not been inconsistent. There had been a proper evidential foundation for the conviction on count two.

4. The offence was between low and medium culpability. There was a low likelihood of harm. The right sentence was a fine of £135,000 with no uplift to reflect turnover.

Work equipment

Workplace Regulations

Heeds v Chief Constable of Cleveland [2018] EWHC 810, High Court

H, a police officer, claimed compensation from the Chief Constable and Tascor for injuries suffered in the course of her employment. The injury was suffered in the custody suite of a police station. The Chief Constable was responsible for the station and Tascor was responsible for its maintenance. H trapped her thumb in the latch of a door. H brought proceedings under the Workplace (Health, Safety and Welfare) Regulations 1992 and the Provision and Use of Work Equipment Regulations 1998. At first instance the claim was dismissed. The judge found that there was no fault in the design or operation of the door, that the potential for harm was not obvious and that if any risk had been identified it would not have justified mitigation measures. The Workplace Regulations applied to the exclusion of the Equipment Regulations. H appealed to the High Court.

Decision

1. Where different sets of regulations applied to the same circumstances, the court had to construe them with a view to avoiding their overlapping application.

2. The judge had correctly found that the door was suitable.

3. The Workplace Regulations rather than the Equipment Regulations applied, given that the Workplace Regulations deal expressly with doors.

4. Whilst the door had potential to cause injury, an assessment had been carried out which considered the degree of risk, including the fact that the door had been used regularly and there were no other reported injuries.

The claim was settled for £175,000.

£1.275 million fine

Health and Safety Executive v Mid-UK Recycling Ltd (2019) Lincoln Crown Court, October 21

An employee of M was working as a line operator at M's site. Blockages occurred on the line and waste was wrapped around an axle, stopping a lower conveyor. As the worker was removing the waste, his glove was caught in the nip between the belt and powered roller of the conveyor. His left arm was amputated above the elbow. The company had failed to prevent access to dangerous parts of the conveyor. A key lock system had been bypassed. This allowed the system to be operated in automatic mode with workers still inside the line's enclosure.

Decision

The company was fined £1.275 million plus £45,000 costs, under section 2 of the Health and Safety at Work, etc., Act 1974.

2018 Cases

Asymptomatic injury

Dryden and others v Johnson Mathey plc [2018] Times, April 3, Supreme Court

Three claimants worked for JM in factories making catalytic converters. The production process involved the use of platinum salts. JM failed to ensure that the factories were properly cleaned. This was a breach of the company's duty under health and safety regulations. As a result, the claimants were exposed to platinum salts and developed platinum salt sensitisation. This was an asymptomatic condition but further exposure could cause an allergic reaction. The claimants; sensitisation was detected. One was given alternative work at a reduced rate of pay. The other two had their employment terminated. The claimants alleged that they had suffered financially through their exposure to platinum salts. The question was whether the exposure was in itself an actionable personal injury.

Decision

1. A change in an employee's physiology caused by the negligence of the employer in exposing him to a dangerous chemical which meant that, although he suffered no immediate symptoms, he was unable to work in the same work because of the risk of worse effects developing after further exposure to the chemical, had suffered actionable personal injury.

2. The absence of symptoms did not prevent a condition amounting to actionable personal injury.

3. The claimants' bodily capacity for work had been impaired and they were significantly worse off.

Contributory negligence

Blackmore v Department for Communities and Local Government [2017] PIQR P1, Court of Appeal

H died from lung cancer aged 74. He had contracted the disease from exposure to asbestos when working in the Devonport Dockyard. Mineral fibre analysis of the deceased's lungs showed a quantity of total retained asbestos fibre above the level at which the risk of contracting lung cancer doubles. H smoked approximately 20 cigarettes a day. Liability of the employer was not in dispute. The sole issue was what apportionment there should be as a result of the deceased's smoking.

Medical experts agreed that death had been caused by the combined effects of smoking and exposure to asbestos. The key concept introduced by the *Law Reform (Contributory Negligence) Act 1945* was the requirement to consider the fault of the person suffering the damage in a comparative process with the fault of the tortfeasor. That process would recognise the respective duties, powers and resources. The imposition of a high standard upon an employer in a comparative assessment reflects Parliament's decision to impose statutory duties on employers and the importance of compliance with those duties. At first instance the judge assessed contributory negligence at 30%. The defendant appealed to the Court of Appeal.

Decision

1. The apportionment of responsibility under the 1945 Act required that account be taken not only of causative potency but also of blameworthiness.

2. There was no reason in principle for drawing a general distinction between a claimant who contributed to his injury by conduct related to his work and conduct unrelated to work.

3. Apportionment on grounds of contributory negligence should not be in the proportions by which exposure to asbestos and smoking increased the risk of contracting lung cancer.

4. There was a particular policy underlying Parliament's strict prohibition of the exposure of workers to harmful substances which needed to be reflected in the apportionment of liability. The judge had been right to give very considerable weight to the blameworthiness of the employer in exposing its employee to asbestos in breach of a strict statutory duty in circumstances where the dangers of asbestos to health were well known. A lesser degree of blame attached to the deceased in continuing to smoke after its dangers had become known.

5. The judge's apportionment of contributory negligence at 30 per cent was well within the range of options open to him.

Death fall from hotel window

Partnership

R v Lear and Lear [2018] EWCA Crim 69, Court of Appeal

L and L were husband and wife partners in a hotel business. A hotel guest fell to his death from a bedroom window. the local authority prosecuted L and L under section 3 of the *Health and Safety at Work, etc., Act 1974 (HSWA)* on the basis that the window created a risk of falling and if L and L had conducted a suitable risk assessment, they would have installed devices to restrict the opening of the windows and reduce the risk of falling. L and L applied for permission to appeal against the judge's conclusions at a preparatory hearing that there was a case to answer under section 3 and that L and L had been properly charged as individual partners because they were joint employers and therefore potentially jointly and severally liable for the actions of the business.

Decision

1. The application was refused.

2. It was a question of fact whether the risk was reasonably foreseeable. All the circumstances were relevant, including the window's proximity to the bed and the height of the opening.

3. The fact that a partnership could be prosecuted did not provide authority for the proposition that only the partnership could be prosecuted. L and L were employers and they had a duty under section 3 in relation to the overall running of the hotel.

4. There was no reason partners should be more favourably treated than directors when they were likely to have more control.

5. The expression 'undertaking' in section 3 was to be interpreted widely so that where the undertaking was the running of a hotel, it was the hotel enterprise as a whole. The employer might be the partnership, an individual partner, or any or all of them.

Duty of care

Mesothelioma

Bussey v 00654701 Ltd (formerly Anglia Heating Ltd) [2018] EWCA Civ 243, Court of Appeal

B's widow appealed against the dismissal of her fatal accident claim after B died from mesothelioma in 2016. B worked for A from 1965 until 1970. In 1970 regulations were introduced which imposed a duty on employers to adopt safeguards against workers' exposure to asbestos. TDN 13, a technical note, was published, which gave guidance on safe levels of exposure to asbestos. Medical evidence stated that there was no minimum risk threshold for exposure to asbestos. At first instance, the claim was dismissed on the basis that the exposure had been below the limit set out in TDN 13. The issue on appeal was whether A had been under a duty to take protective measures.

Decision

1. The appeal was allowed.

2. The overall test of an employer's duty was that of the reasonable and prudent employer taking positive thought for the safety of workers in the light of what was known or should have been known, and keeping abreast of developing knowledge.

3. Since the employer had brought no factual evidence as to the state of knowledge in the 1960s, it was not possible to determine liability, and the case would be remitted.

4. Given that anyone who worked in proximity to asbestos faced some risk of mesothelioma, and that it was not possible to eliminate that risk altogether by taking precautions, the residual risk after taking all proper precautions might be regarded as acceptable.

Manual handling

Risk assessment

Stewart v Lewisham and Greenwich NHS Trust [2017] EWCA Civ 2091, Court of Appeal

S, a midwife, was injured when she lifted an oxygen box, weighing 8 kg. This was a very frequently used piece of equipment. The box was designed to be lifted by its handle. No risk assessment had been carried out in relation to manually handling the box. S picked up the box by putting her hands underneath it. She suffered a back injury and it was later discovered that she suffered from a degenerative back condition. S alleged that lifting the box needed a risk assessment under the *Manual Handling Operations Regulations 1992*. At first instance, her claim for compensation was dismissed. She appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. There had been no real risk of injury and no detailed risk assessment was required.

3. There was no evidence that handling of the box had given rise to difficulties or complaints over many years.

4. The lifting operation was not risky for any normal person but S's pre-existing condition had been triggered.

5. The box's weight was well within the boundary stated in HSE guidance within which it was unlikely to create a risk of injury sufficient to warrant a detailed assessment.

Prison assault

Kaizer v Scottish Ministers [2017] CSOH 110, Scottish Outer House

K, a prisoner who is a Polish national, was assaulted by a fellow prisoner in the Polish gym. The jury found that the attacker was guilty of attempted murder and that the attack was racially motivated. A week before the attack, the attacker had pleaded guilty to attempting to

murder another Polish male. K claimed that the attack followed a threat made to him which he has reported to a prison officer. On his behalf it was argued that it was reasonably foreseeable that a threat of violence could lead to actual violence. K claimed compensation from the Scottish Ministers.

Decision

1. Scottish Ministers were liable.

2. The attacker's racially hostile disposition supported the credibility of K's account.

3. The prison officer to whom K reported the threat should have reported it. If he had done so, it was much more likely that the assault would not have happened.

4. The facts of the present case fell within the circumstances in which prison authorities could be liable for assaults by one prisoner on another. The threat which K had reported showed that he was at particular risk of violent attack.

5. The prison officer had not taken reasonable care to prevent the implementation of the threat.

Prohibition notice

Appeal

HM Inspector of Health and Safety v Chevron North Sea Ltd (Scotland) [2018] UKSC 7, Supreme Court

C operates an offshore installation in the North Sea. In April 2013 the installation was inspected by HSE inspectors. They found that corrosion had made the stairways and staging to the helicopter landing platform unsafe. They served a prohibition notice under section 22 of the *Health and Safety at Work, etc., Act (HSWA).* In May 2013 C appealed against the prohibition notice to an employment tribunal, under section 24 of HSWA. C removed the metalwork from the landing platform and arranged for it to be tested. Test results showed that the metalwork passed the British Standard strength test. There was no risk of workers being injured by falling through the metalwork. C sought to rely on the expert report in its appeal.

The issue in the case was whether the employment tribunal is confined to material which was, or could reasonably have been, known to an inspector at the time when the notice was served, or whether it can take into account additional, later evidence.

Decision

1. The appeal was dismissed.

2. On an appeal under section 24, the tribunal is entitled to take into account all available evidence relevant to the state of affairs at the time of the service of a prohibition notice, including information coming to light after it was served.

3. It is vital for inspectors to be able to take prompt and effective action to ensure compliance with HSWA. A prohibition notice is a powerful tool which allows an inspector to step in

when he takes the view that a particular activity will involve a risk of serious injury. It also encourages employers to have good systems in place to improve public safety.

4. The service of a prohibition notice on a business has the potential to do it financial and reputational harm.

5. Section 24 does not make clear what information a tribunal can take into account when forming a view of the facts at the material time. This issue must be considered in the light of the statutory scheme as a whole.

6. An appeal against a prohibition notice is not against the opinion of the inspector but is against the notice itself. In the present case, the tribunal had to decide whether the helideck stairways were so weakened by corrosion as to give rise to a risk of serious personal injury. There was no good reason for confining the tribunal's consideration to the material which was, or should have been, available to the inspector. The tribunal must be entitled to have regard to other evidence which helps to ascertain what the risk actually was. If the evidence shows that there was no risk at the material time, then the notice may be modified or cancelled.

7. It is not a criticism of an inspector when new material results in a different conclusion from the one which he reached. The inspector's decision is often taken as a matter of urgency and without the luxury of comprehensive information.

8. The effectiveness of a notice is not reduced by an appeal process which enables the reality of the situation to be examined by a tribunal with the benefit of additional information.

9. This, a wider interpretation of section 24, does not undermine the role of prohibition and improvement notices in encouraging employers to have robust systems in place to show that no risk exists and therefore avoid the disruption of of a prohibition notice which remains in force during the appeal process unless suspended by the tribunal.

10. The HSE's arguments that allowing the tribunal to look beyond material available to the inspector would cause delay and cost, do not change the conclusion on the wider interpretation of section 24. An appeal must be lodged within 21 days and is then under the control of the tribunal.

11. If the HSE's arguments were accepted, a notice could not be modified or cancelled even if a perceived risk of injury never existed.

12. Even if the inspector would not seek to enforce the order, the notice could still damage the reputation of the employer and his ability to do business.

Res ipsa loquitur

PT Civil Engineering v Davies (2017) EWHC 1651, High Court

D was driving a vehicle owned by PT. A fire started in the vehicle and D leapt from the vehicle and was injured. At first instance, the court found PT liable for D's injuries on the basis that there was no known cause for the fire. The vehicle was poorly maintained and it was inferred that was the cause of the fire. PT appealed to the High Court.

Decision

1. The appeal was allowed.

2. PT owed a duty to D to take reasonable care to ensure that the vehicle that was provided to D was safe for the purposes for which it was to be used.

3. There were cases where the claimant could not show the precise cause of the accident but the circumstances were such that the accident would not have happened in the ordinary course of events without negligence (res ipsa loquitur). In such circumstances, a court might infer that the defendant failed to take reasonable care and was responsible for the accident unless the defendant adduced evidence to rebut the suggestion that it was negligent.

4. The judge at first instance had been wrong to draw the inference which he did, on the facts as found by him. The facts were not such as to enable the inference to be drawn that it was PT's negligence which caused the fire.

Sentencing

Very large organisation

R v Whirlpool Appliances Ltd [2018] ICR 1010, Court of Appeal

In March 2015 D, a self-employed fire alarm and telecoms contractor, was working at W Ltd's Indesit factory in Yate. He was working on fire and heat detector systems from a mobile elevated working platform between hanging baskets on an overhead conveyor system. A basket struck the platform and D fell. He suffered multiple injuries and died ten days later. W Ltd was convicted of an offence under section 3 of the *Health and Safety at Work, etc., Act 1974*. It had not required D to prepare a job-specific risk assessment and method statement for his work and had not prepared a detailed permit to work which would have identified the potential risk posed by a working platform being used near the overhead conveyor and the required control measures. W Ltd was fined £700,000. The company appealed to the Court of Appeal on the basis that the sentence had been manifestly excessive.

Decision

1. The fine was reduced to £300,000, applying the Definitive Guideline on Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences. The Court set out a detailed analysis of the Guideline.

2. W Ltd was a 'very large organisation' with a turnover of several multiples of £50 million. The starting point for the fine should be £500,000, reduced to £450,000 for mitigation.

3. Taking into account the guilty plea, the appropriate fine was £300,000.

Smoking ban in prisons

R (on the application of Black) v Secretary of State for Justice [2017] UKSC 81, Supreme Court

B is serving an indeterminate prison sentence. He is a non-smoker who suffers from health problems exacerbated by tobacco smoke. He complained that the smoking ban imposed by the *Health Act 2006* was not being properly enforced in the prison. He issued proceedings for judicial review of the Secretary of State's refusal to provide access for prisoners to the National Health Service Smoke-free Compliance Line. This would enable prisoners to report breaches of the smoking ban if the ban applied to Crown premises. At first instance the High Court found that the smoking ban bound the Crown. On appeal to the Court of Appeal, that decision was reversed. B appealed to the Supreme Court.

Decision

1. The appeal was dismissed.

2. Parliament must have intended that the Crown should not be bound by the smoking ban, or it would have made express provision for it.

3. A statute does not bind the Crown except by express words or necessary implication. This is not an immunity from liability but a rule of statutory interpretation.

4. A 'necessary implication' is one which necessarily follows from the express provisions of the statute construed in their context, including its purpose.

5. The test to be applied was whether, in the light of the words used, their context and the purpose of the legislation, Parliament must have meant the Crown to be bound by the smoking ban.

6. The Act did not say that the smoking ban bound the Crown, as it could easily have done. This contrasted with similar statutes, for example the *Health and Safety at Work Act 1974*, which contain express provisions on how and to what extent they apply to the Crown.

7. Even if it was desirable for the smoking ban to bind the Crown, the legislation is quite workable without this. The Crown could do a great deal by voluntary action to fill the gap.

Vicarious liability

Employment status

Grubb v Shannon (2018) Rep LR 48, Glasgow Sheriff Court

G, a beauty therapy customer, claimed compensation from a salon owner for injuries caused by a self-employed beauty therapist in the salon. G had suffered an allergic reaction from dye used in a treatment. G alleged that the therapist had been in breach of her duty of care and that the salon owner was vicariously liable.

Decision

1. The owner was vicariously liable.

2. It was just, fair and reasonable for vicarious liability to be imposed. There was a relationship akin to employment.

3. The therapist had undertaken activities entrusted to her by the salon owner as an integral part of business activities and for the benefit of the owner.

4. The negligence had been a risk created by the owner by assigning those activities.

5. The therapist's negligence had been sufficiently closely connected to her relationship with the owner to justify the imposition of vicarious liability.

2017 Cases

Contributory negligence

Anderson v Imrie and another [2016] CSOH 17, Scottish Outer House

Facts The mother of an 8 year-old child arranged with the wife of a farmer for him to play with the farmer's 5 year-old son on the farm. The child tried to get through a gate across a doorway to a stable. The gate was attached to the stable by a chain or a rope at its top righthand corner. It was not connected at the other end. The child stood on one of the rails of the gate and reached up to detach or loosed the chain. The gate toppled onto him, crushing him and causing his head to strike a concrete surface.

Decision

1. The child was partly to blame for the incident.

2. Although he was 8 years old, he would have been aware that he should comply with the farmer's wife's instruction not to enter that area of the farm.

3. He would also have been aware that it was dangerous to climb onto and interfere with the heavy gate by detaching it from the barrier.

4. The child was 25% to blame for the incident.

Ex turpi causa non oritur actio

'from a dishonourable cause an action does not arise'

D Geddes (Contractors) Ltd v Neil Johnson Health & Safety Services Ltd [2017] CSON 42, Scottish Outer House

DG Ltd, a quarry operator, was fined £200,000 for a breach of the *Quarries Regulations 1999*. A worker had been killed at DG Ltd's quarry when a lorry was reversed into a feed hopper. The HSE had decided that a bund, which was intended to prevent such incidents, was ineffective. DG Ltd had engaged N as a health and safety adviser. N had carried out regular inspections and had provided reports. DG Ltd sought to recover £200,000 from N on the basis that an ordinarily competent health and safety adviser, exercising ordinary skill and care, would have advised that the bund was defective. If DG Ltd had been advised of this, it would have taken steps to rectify the defects before the incident and prosecution. N argued,

as a preliminary point, *ex turpi cause non oritur actio* – DG Ltd could not recover a penalty imposed upon it for its own criminal act.

Decision

1. There was no authority for the proposition that recovery of a loss consisting of a criminal penalty or the consequences of a criminal sanction was necessarily excluded by the ex turpi causa principle.

2. Intentional wrongdoing on the part of the claimant was not the only basis upon which a right of recovery of criminal penalties might be excluded. It could also be excluded by negligence.

3. The case could proceed.

Fines for offences

£1,750,000

Scottish Power Generation Ltd v HM Advocate [2016] SLT 1296, Scots High Court

S Ltd pleaded guilty to failing to ensure the health and safety of its employees. E, an employee, had been seriously injured in October 2013 when he was engulfed in pressurised steam from a faulty valve. The fault had been identified in 2009. S Ltd had failed to repair or replace the valve and a short-term safety measure had been removed without explanation and not replaced. At first instance, the company was fined £1,750,000. The Scottish court stated that the circumstances of the offence showed a breach of duty falling far short of the appropriate standard. The company had no explanation for any of the failures regarding the valve and those failures came within the description of high culpability for the purposes of the 2015 Sentencing Council of England and Wales guidelines. Applying the guidelines, S Co came within the description of a very large company. The starting point for the offence was £1.1 million, with a range between £550,000 to £2.9 million. The appropriate starting point was £2.5 million. This was reduced to £1.75 million, taking into account the company's early guilty plea. The company appealed.

Decision

1. The appeal was allowed and the fine reduced to £1,200,000.

2. The court would have considered a starting point of £1.5 million, having regard to the serious breach, mitigating circumstances, the serious injury, the absence of a fatality and the fact that S Ltd was part of a multinational corporation.

3. There was no explanation as to the manner in which the court below had arrived at the figure of £1,750,000 with regard to pre-guideline Scottish decisions. That court had recognised that in so far as the guidelines might be applied, it would produce a higher level of fine than in the earlier Scottish cases.

4. Using the 2015 guidelines as a cross check to the figure of £1.5 million, the sum selected was reasonable. A discount of 20 per cent was reasonable, to produce a fine of £1.2 million.

Levels of fines

Health and Safety Executive v Bam Ferrovial Kier (2017) Southwark Crown Court, July 28

Statutory reference: regulation 10 of the Work at Height Regulations 2005 (WAH) and regulation 22 of the Construction (Design and Management) Regulations 2007 (CDM).

In March 2014 Rene Tkacik, from Slovakia, was working on a team enlarging the Crossrail tunnel by removing tings of the pilot tunnel and spraying walls with wet concrete. A section of the roof collapsed and Tkacik was crushed to death by wet concrete,

In January 2015 Ian Hughes was collecting equipment from inside a tunnel when he was struck by a reversing excavator. He suffered serious injuries. Also in January 2015 Alex Vizitiu, who was part of a team spraying liquid concrete, was cleaning pipes which supplied the concrete. One of the pipes was disconnected and he was struck with pressurized water and concrete debris. He suffered serious injuries.

There had been a failure to provide a safe system of work, a failure to properly maintain the excavator which reversed into Hughes, and a failure to enforce exclusion zones.

Bam Ferrovial Kier was fined £300,000 under regulation 10 of WAH and £765,000 for offences under regulation 22 of CDM.

The HSE Head of Operations commented that all three workers were taking part in one of the most important and challenging infrastructure projects of the decade. It was the company's duty to protect its dedicated and highly-skilled workforce.

Negligence

Duty of care

Social utility

Humphrey v Aegis Defence Services Ltd [2017] 2 All ER 235, Court of Appeal

H worked for ADS providing close protection security services in Iraq during postwar reconstruction. He was part of a team which included one Iraqi interpreter. Teams were expected to maintain a good level of fitness and they were required to undertake simulation exercises. The fitness levels of the interpreters were lower than those of the contractors. During one exercise, the interpreter dropped the handle of a loaded stretcher and injured H's shoulder. He claimed compensation from ADS for the injury. At first instance the claim was dismissed on the basis that the reconstruction work was a desirable activity for which interpreters were essential. It would not have been reasonably practicable for the employers to have imposed a minimum fitness level before recruiting interpreters. H appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. The risk of harm, the nature and gravity of that risk and the social utility of the activity were all factors to be taken into account in determining the nature and scope of any duty of care.

3. There was a foreseeable modest risk of harm resulting from the dropping of the stretcher, resulting in soft tissue injury. Given the scarcity of Iraqis willing to act as interpreters, the importance of their role and of their integration into contractors' teams, and the modest degree of risk involved, it was impossible to say that the employers were at fault in failing to take further steps to ensure that the interpreters were fit enough to undertake the simulation exercise.

Occupiers liability

English Heritage v Taylor [2016] PIQR P14

In 2011 T was visiting Carisbrooke Castle on the Ilse of Wight when he stepped down a steep path from an elevated platform, fell and suffered a head injury. Below the path was a sheer drop which could not be seen from the platform. T alleged that English Heritage was negligent and/or in breach of s.2, *Occupiers' Liability Act 1957*, for failing to warn of the dangers at the bottom of the path. At first instance, the claim succeeded. The court stated that warning signs should have been placed on the platform because the sheer drop was not evident from the platform. T was 50% contributorily negligent. English Heritage appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. It would not have been obvious to a person standing on the platform that the sheer drop continued below the path.

3. The defendant should have taken reasonable steps to protect visitors.

4. A sign warning visitors of the sheer drop would, on the balance of probabilities, have stopped T from taking the steep path as he did.

5. The finding on contributory negligence stood.

6. The argument put forward by English Heritage that it was against the public interest to hold them liable, and would lead to an unduly defensive approach to historic sites, was not accepted.

7. The finding should not be interpreted as requiring occupiers to place unsightly signs in prominent positions all over sensitive historic sites.

Serious hand injuries

Construction company fined

Health and Safety Executive v Coldmac Ltd (2017) Nuneaton magistrates' court, March 28

Statutory reference: regulation 11 of the Provision and Use of Work Equipment Regulations 1998 (PUWER).

Coldmac Ltd, a construction company, has been fined following an incident in which a worker suffered serious hand injuries.

The facts:

- The company was engaged as specialist contractor for a new footway. In April 2015 a worker was using a screwdriver to scrape asphalt residue from a mixer. The screwdriver slipped and the worker caught his hand on the mixer. Two of his fingers were severed.
- The guarding on the mixer was below the safety standards required for workers to operate the machinery safely.

Decision

The company was fined £6000 plus £1900 under regulation 11 of PUWER.

An HSE inspector commented after the case that it highlighted the importance of safely checking equipment and machinery, ensuring that employers had appropriate guarding to avoid serious injuries.

Tripping and slipping

McLeish v Lothian NHS Board [2017] CSOH 71, Scottish Outer House

M, a nurse, slipped on a wet floor in a hospital. She suffered a fractured arm, dental damage and complex regional pain syndrome. She also developed a depressive episode which was controlled with medication. She had no warning that the floor was wet, she had not known that it was wet and she would not have entered the wet area if she had seen a wet floor sign at its entrance. There was no wet floor sign. A cleaner who had mopped the floor stated that she had placed a trolley at the entrance to the room to indicate that the floor was wet. the way in which she had mopped the floor meant that it was not obviously wet. M claimed compensation from her employer on the basis of a breach of regulation 12 of the *Workplace (Health, Safety and Welfare) Regulations 1992*.

Decision

1. The claim succeeded.

2. Compensation of £40,000 would be awarded. This was a less severe injury resulting in some permanent disability.

3. M had been given no warning that the floor was wet. A wet floor sign was a reasonably practicable measure.

Vicarious liability

Assault after Christmas Party

Bellman v Northampton Recruitment Ltd [2017] IRLR 124, High Court

B, an employee of N, went to the company's Christmas party. After the party, a number of guests went on to a hotel and carried on drinking. The company's managing director assaulted B in an unprovoked attack. He punched B twice. B struck his head on the floor and suffered serious brain damage. He claimed compensation from the company.

Decision

1. The company was not liable.

2. The assault was committed after and not during an organised work social event.

3. The managing director could not always be considered to be on duty.

4. There was a temporal and substantive difference between the Christmas party and the drinks at the hotel. Given the time and place, no objective observer would have seen any connection with the jobs of the employees present.

5. There was an insufficient connection between the position in which the managing director was employed and the assault to make it right for the company to be held liable.

Work equipment

Evidence

Casson v Hudson [2017] PIQR P226, Court of Appeal

C was serving a prison sentence. He was working at a church in Blackpool as part of his resettlement day release. He fell from a ladder while doing decorating work and suffered serious injuries. His supervising community worker had told him not to use ladders and he had signed a placement memorandum of understanding to that effect. C brought proceedings in negligence and breach of statutory duty under the *Provision and Use of Work Equipment Regulations 1998*, arguing that he was owed duties as an employee of the church. The defence argued that C had not been instructed to decorate but had chosen to do so at his own initiative and instigation. The trial judge rejected the claim that C was an employee and dismissed all C's claims. C appealed to the Court of Appeal on the basis that the trial judge was wrong to find that C had not been instructed to carry out the decorating work and that the community officer supervising him had not seen him using a ladder before.

Decision

1. The appeal was dismissed. The trial judge had been entitled to reject C's evidence that he had been instructed to carry out painting work.

2. The defendants did not assume control over C. They did not direct how he carried out his work, did not seek to control him and did not attempt to instruct or direct him. There was no liability under the 1998 Regulations.

2016 Cases

Asbestos

Causation

Carder v Secretary of State for Health and University of Exeter [2015] EWHC 2399, High Court

C developed asbestosis as a result of being negligently exposed to asbestos in the course of his work as an electrician. It was agreed that the second defendant was responsible for 2.3% of the total exposure. The medical evidence indicated that this proportion had made no discernible difference to C's condition. In reliance on this evidence, the second defendant argued that its negligence had not resulted in an actionable injury.

Decision

The question was whether the C had suffered real damage and was worse off to a degree that was not so trivial that a claim in damages was not justified. Although a 2.3% contribution was small, it was not de minimis. Asbestosis is a divisible disease and each source of asbestos exposure contributes in proportion to the overall condition. The second defendant's contribution to that exposure caused the C to be worse off physically, even if not in a way that was noticeable or measurable. Accordingly, C had suffered actionable damage.

The second defendant was therefore liable for 2.3% of the C's damages, which were assessed at £67,500 on a provisional basis, including £60,000 for pain, suffering and loss of amenity.

Careless acts of employee

Polyflor Ltd v Health and Safety Executive [2014] EWCA Crim 1522, Court of Appeal

A worker suffered a fractured arm while clearing a blockage on the roller of a conveyor used to recycle vinyl material. In order to check adjustments, guards had to be removed while the machine was running. The employee raised a permit to work to run the unguarded machine. He attempted to push the conveyor belt with a spanner. His arm was drawn into the machine. He admitted that he had acted foolishly. The employer was convicted of a health and safety offence and appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. The prosecution had only to show some evidence of exposure to risk.

3. Once that was established, the burden shifted to the employer to show on the balance of probabilities that it did all that was reasonably practicable to ensure that its employees were not exposed to such risk.

4. The prosecution did not have to prove that a particular accident was foreseeable, merely that a danger had been created.

5. The creation of a material risk through the carelessness of an employee remained a material risk for that purpose.

Duty of care

Personal protective equipment

Majid v Chief Constable of Scotland (2016) SLT 1, Lothian Sheriff Court

M claimed compensation for an eye injury suffered in the course of his employment. He was injured while demonstrating a headlock escape technique. He gave evidence that a colleague (S) had acted contrary to the proper technique and his fingernail struck M in the eye.

Decision

1. S had been under a duty to take reasonable care for M's safety. His actions had been negligent and this had caused the incident.

2. A residual risk had existed, so that Regulation 4 of the *Personal Protective Equipment at Work Regulations 1992* had been engaged. The training co-ordinator's risk assessment had been inadequate.

3. The provision of goggles would not have been effective to prevent injury without increasing overall risk. The claim under the 1992 Regulations failed.

4. The provision of gloves was not appropriate and would have been disproportionate, particularly as the PPE Regulations required equipment to be provided to the person who was likely to be injured rather than anyone else.

5. Quantum of £7000 was agreed.

Employers' liability insurance

Company in liquidation

Campbell v Peter Gordon Joiners Ltd (In Liquidation) and Another (2016) The Times, July 20, Supreme Court

C was employed by PGJ as an apprentice joiner. He suffered an injury while working with an electrical circular saw. PGJ's employers' liability insurance excluded claims arising from the use of woodworking machinery powered by electricity. This was a breach of the 1969 Act. The company went into liquidation. C sought to hold G, as director of the company, liable in damages for the company's failure to provide adequate insurance cover.

Decision

1. The claim failed.

2. The 1969 Act imposed criminal liability and the general rule was that there was no civil liability.

3. There was no suggestion that a person could be made indirectly liable for breach of an obligation imposed by statute on someone else. It was no different where the obligation was imposed on a company.

4. The 1969 Act imposed direct responsibility only on the employer. The responsibility of a director was imposed by a specific and closely defined criminal penalty.

Mesothelioma

Burden of proof

Atkinson v Secretary of State for the Department of Energy and Climate Change [2014] EWHC 3773, High Court

A, the widow of H, claimed compensation from S for the death of her husband. H was employed as a colliery worker in the 1970s and 1980s. In 2008 he died from mesothelioma. Before he died, he stated that he had been exposed to asbestos while inspecting conveyor belts at a colliery between 1979 and 1984. He alleged that friction brakes which contained asbestos were used to control the conveyor belts and that the brake pads created asbestos dust to which he had been exposed. On behalf of S it was stated that the brakes had been phased out and replaced with a system which did not contain asbestos. The rakes were protected by guards and H did not carry out repairs. S also argued that H's statement was riddled with errors and was undermined by previous inconsistent statements.

Decision

1. The claim was dismissed.

2. S had owed H a duty of care not to expose him to material which was likely to cause reasonably foreseeable injury, subject to the standard of knowledge which prevailed at the relevant time.

3. A stricter statutory duty of care was also owed under section 74(2), Mines and Quarries Act 1954.

4. A note from H's solicitor to a coroner which stated that the anti-rollback system had been in use during H's employment was double hearsay which was unsworn and uncontested in cross-examination.

5. H's statement was unreliable.

6. H would not have been close to any dust on the very few occasions of brake failure. That exposure had diminished as the friction brakes were phased out.

7. H had been exposed to asbestos but the level of exposure was considerably lower than he had claimed and the burden of proof had not been discharged.

Personal protective equipment

Kennedy v Cordia (Services) LLP [2016] ICR 325, Supreme Court

Statute reference: Personal Protective Equipment at Work Regulations 1992 (PPE), reg.4; Management of Health and Safety at Work Regulations 1999 (MHSWR), reg.3

C was employed in Scotland by CS as a carer. She slipped and fell on an icy path leading to a client's house and injured her wrist. She claimed compensation from CS on the following grounds:

- Their assessment of the risk of carers falling on snow or ice had been inadequate, in breach of MHSWR.
- They had failed to ensure that suitable PPE was provided or that the risk was adequately controlled by other means which were equally or more effective, in breach of the PPE regulations.
- Breach of the common law duty of care.

CS had carried out a risk assessment which assessed the risk of slipping or falling in inclement weather as tolerable. Despite a history of similar incidents, CS had not considered providing PPE, for example anti-slip footwear attachments, and had advised carers to wear appropriate footwear. Evidence was given by a consulting engineer with qualifications and experience in this area.

At first instance, the claim succeeded. On appeal, this decision was reversed. The Court of Session found as follows:

- The evidence of the engineer had been impermissibly admitted.
- The PPE regulations did not impose a duty on employers to take precautionary measures.
- The MHSWR regulations were concerned only with the task performed by the employee and not with K's journey to the client's home.
- The risk of slipping had been adequately controlled by CS's instructions.

K appealed to the Supreme Court which allowed the appeal and made the following points:

- The health and safety practice of employers could properly be the subject of expert evidence. K's expert gave evidence of factual matters, which was admissible because it was relevant and might assist a judge.
- An employee was "at work" for the purposes of the PPE regulations and the MHSWR regulations throughout the time when she was in the course of her employment. This included travelling to a client's home.
- The risk of K's slipping on snow and ice was obvious. It was known to CS and could not be avoided. It therefore had to be evaluated and CS had given no consideration to the possibility of individual protective measures. CS was therefore in breach of the PPE regulations and the MHSWR regulations.

K had been obliged to visit clients in their homes, regardless of hazardous conditions underfoot. At common law an employer was bound to take reasonable care for the safety of its employers. If CS had made proper inquiries into the risk of employees slipping or falling,

it would have learned that attachments were readily available which were effective in reducing that risk. CS had been negligent in failing to provide such attachments.

Prohibition notices

Appeal

HM Inspector of Health & Safety v Chevron North Sea Ltd (2016) Scottish Inner House 29

A prohibition notice was served on C, the operators of an offshore installation. The main access to the installation was by helicopter. Access to the helipad was by stairways which led to staging around the perimeter of the helipad. In April 2013 an HSE inspector visited the installation. He identified significant corrosion on the stairways and served a prohibition notice on the basis that the stairways were unsafe and that their use would involve a risk of serious personal injury.

The installation manager undertook that remedial work would be carried out immediately and that the stairways would not be used until it was completed. C arranged for the stairways to be taken to Exova for testing. The test concluded that the stairways complied with British Standards. C appealed against the prohibition order. The HSE objected to the admission of the Exova test in evidence. The employment tribunal cancelled the notice. Evidence which had arisen after the notice could be taken into account. The condition of the stairways was not such as to pose a risk of serious personal injury. The HSE appealed to the Scottish Inner House.

Decision

1. The appeal was dismissed.

2. An appeal against a prohibition notice was not confined to points of law. An appeal on the facts was equally open.

3. Bearing in mind the effect which a prohibition notice might have on an operator's business, it would be strange if an operator could not mount a successful appeal based upon the simple contention that whatever the inspector thought at the time based on the information before him, it was now known that the risk did not exist.

4. This analysis had no bearing upon an inspector's ability to act in the interests of health and safety when he formed the opinion that a risk existed. The emergence of new material to negate the risk did not in itself invalidate the notice or its effect at the time.

Vicarious liability

Violence at work

Key Supreme Court decision

Mohamud v Morrison Supermarkets plc [2016] UKSC 11

The Supreme Court has given a landmark judgment in this area of law.

The facts of this important case were that on 15 March 2008 M entered MS plc's premises in Small Heath, Birmingham which include a petrol station and a kiosk where customers pay for their purchases. Having parked his car, he entered the kiosk to ask whether he could print some documents from a USB stick. Amjid Khan was behind the kiosk desk, employed by MS plc to see that petrol pumps and the kiosk were kept in good order and to serve customers. Khan refused M's request in a rude manner, at which M protested. Khan responded in foul, racist and threatening language and ordered M to leave. M returned to his car followed by Khan.

Before M could drive off, Khan opened the passenger door, told M in threatening words never to return and punched him on the left temple. M got out and walked round to close the passenger door when Khan subjected him to a serious attack. M had not done anything which could be considered aggressive or abusive.

M brought proceedings against MS plc on the basis that it was vicariously liable for the actions of its employee Khan. The trial judge dismissed the claim because he considered that there was an insufficiently close connection between what Mr Khan was employed to do and his tortious conduct in attacking M for MS plc to be liable. The Court of Appeal upheld the judge's decision.

M appealed to the Supreme Court, challenging whether the 'close connection' test was the appropriate standard to apply and also arguing that his claim should have succeeded in any event.

The Supreme Court unanimously allowed the appeal Claimant. It made the following points:

- The court has to consider two matters. First, the court must ask what function or field of activities has been entrusted by the employer to the employee (i.e. what was the nature of his job). This is to be viewed broadly.
- Second, the court must decide whether there was a sufficient connection between the position in which he was employed and his wrongful conduct to make it right for the employer to be held liable. Applying that test here, it was Khan's job to attend to customers and respond to their inquiries. His conduct in responding to M's request with abuse was inexcusable, but interacting with customers was within the field of activities assigned to him by his employer. What happened thereafter was an unbroken sequence of events.
- The connection between the field of activities assigned to Khan and his employment did not cease at the moment when he came out from behind the counter and followed M onto the forecourt. There are two reasons to draw this conclusion. First, it is not correct to regard Khan as having metaphorically taken off his uniform the moment he stepped out from behind the counter - he was following up on what he said to M. Secondly, when Khan followed M to his car and told him not to come back to the petrol station, that was not something personal between them, but an order to keep away from his employer's premises. In giving the order he was purporting to act about his employer's business

- Khan's motive in the attack was irrelevant. It did not matter whether he was motivated by personal racism rather than a desire to benefit his employer's business.

Work equipment

Work at height

Mclellan v Mitie Group plc 2015 SLT 861, Scottish Outer House

Statute reference: Provision and Use of Work Equipment Regulations 1998; Work at Height Regulations 2005

M was a cleaner employed by MG. Her work included filling a bucket with hot water from a sink in an equipment cupboard. She filled the bucket from a boiler next to the sink because the sink taps had never worked. The boiler had to be refilled and while she was waiting for the boiler to refill she wedged the bucket underneath the boiler on a flat surface next to the sink. The bucket fell and splashed her legs with boiling water. She claimed compensation for breaches of the 1998 and the 2005 Regulations.

M's supervisor gave evidence that she had not known of any fault with the taps and that she had not told workers to use the boiler. On M's behalf it was submitted that there had been no proper system in place to maintain the sink taps in working order and to ensure a safe supply of hot water for cleaning purposes. For the employer, it was submitted that the incident had been caused by M's actions in placing the bucket underneath the boiler and leaving it there, and she should have placed the bucket in the sink.

Decision

1. The claim succeeded.

2. The process of filling the bucket required a period where the boiler was being refilled. The bucket had to be placed somewhere. But for the failure of the taps, M would not have used the boiler and would not have had to place the bucket.

3. A system of maintenance of equipment which relied entirely upon reporting by the worker using the equipment was not adequate or proper. Where the hot water supply from the taps was inadequate, the use of the boiler had been expected by the employer and was in any event the obvious step to take.

4. The risks inherent in the use of the boiler were clearly foreseeable and extended to consideration of the careless cleaner under pressure to complete her tasks.

5. If the employer had not wanted the boiler to be used, it should have given instructions or put up a sign to that effect. If it had intended the boiler to be used, it should have taken steps to guard against the risk of the bucket of hot water from falling or splashing.

6. M's contributory negligence was assessed at 20%.

2015 Cases

Burden of proof

Health and Safety Executive v Polyflor Ltd [2014] ICR 1142, Court of Appeal

Statute reference: Health and Safety at Work, etc., Act 1974, s.2

P Ltd was a company which manufactured vinyl floor covering. It used a machine to recycle unused vinyl products. The machine often jammed and had to be manually cleared. In 2007 an engineer was injured when he tensioned and realigned the machine after clearing a blockage. The company reassessed the machine so that tracking and alignment could be adjusted without removing guards.

In 2011 a technical support engineer was given a permit to work on the machine without removing guards, in order to track it. He used a spanner to ease the rubbing of a conveyor belt. The spanner caught in the machine and he suffered a fractured arm. P Ltd was charged with an offence under section 2 for failing, so far as was reasonably practicable, to ensure the health and safety of employees. In giving evidence at the trail, the engineer accepted that what he had done was foolish. At the close of the prosecution case, it was submitted on behalf of the company that there was no case to answer because no material risk had been established in that a risk would only materialise if an employee did something foolish. The judge rejected this submission and the company was convicted by the jury. The company appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. The prosecution did not have to prove that a particular accident was foreseeable.

3. Causation was not an element of an offence under section 2 of the Act.

4. For the case to go to the jury, the prosecution had only to adduce some evidence that an employee was exposed to the risk of danger.

5. The creation of a material risk by the carelessness or gross carelessness of an employee remained a material risk for that purpose.

6. Once that had been established, the onus shifted to the defendant to show, on the balance of probabilities, that it did all that was reasonably practicable to ensure that employees were not exposed to such risk.

7. Any machine with moving parts had to be guarded because of material risks to health and safety which exposure to such moving parts might give rise.

8. P Ltd, under a permit to work system, had allowed the running of the machine with its guards removed so that a maintenance operation could be carried out while the machine was still in operation.

9. In that situation employees were exposed to a clear, obvious and material risk to their health and safety and to the consequences of their own foolishness.

10. A jury is more likely to be persuaded that an employer has probably done all that could reasonably have been done to obviate an obvious risk if it adduces a positive case that other options have been considered but, for whatever reason, none has been considered reasonably practicable. It is then for the jury to evaluate the evidence.

Course of employment

Vaughan v Ministry of Defence [2015] EWHC 1404, QB

V, a marine, was being trained to sail in the Canary Islands. During his free time, resulting from adverse weather conditions, he went swimming in the sea and suffered a catastrophic spinal injury. He claimed compensation from the MOD on the basis that his injury had been suffered in the course of his employment. It was argued on his behalf that he had been on duty at the time of the incident and that marines were required to take physical exercise.

Decision

1. The claim failed.

2. V had not been doing something reasonably incidental to his employment.

3. V's swim had not formed part of his physical training but had been a recreational dip in the sea.

Foreseeability

Jones v Scottish Opera (2015) SLT 401, Scottish Outer House

J, a self-employed production manager, claimed compensation from S for injuries which he suffered when he tripped and fell from a trailer owned by S. In December 2013 J descended from the trailer after unloading theatre equipment. J stated that he had tripped on a metal ridge or lip at the edge of the trailer and that S had failed to provide a ramp which would have prevented the accident. Further, the drop of one metre from the trailer to the ground was a hazard in itself. J suffered a soft tissue fracture of the wrist which was likely to cause long-term discomfort.

Decision

1. S was liable.

2. There had been no ramp and if there had been one, J would have walked down it and avoided injury.

3. There was no hazard at the edge of the trailer which might pose a danger to persons getting in or out of it.

4. It was S's responsibility to provide a ramp and it was standard practice for a company such as S to provide one.

5. J's injury had been foreseeable. Accessing the trailer at a height of one metre carried inherent risks.

6. J had not been contributorily negligent.

Hazardous substances

Asbestos risk

MWH UK Ltd v Wise (Inspector of Health and Safety) [2014] EWHC 427, High Court

Statute reference: Construction (Design and Management) Regulations 2007

W, an HSE inspector, had issued an improvement notice on M Ltd following the exposure to asbestos of employees involved in a refurbishment project. The improvement notice referred to a finding that M Ltd had gathered pre-construction information (PCI) without having the necessary level of competence to be able to provide suitable advice regarding the risk of the presence of asbestos. The notice required training to be undertaken. M Ltd appealed to the employment tribunal. The tribunal upheld the notice, with some modification. M Ltd appealed to the High Court.

Decision

1. The appeal was dismissed.

2. The duty on M Ltd was to check the PCI and to advise on significant gaps .M Ltd was construction design and management coordinator. It was the key safety advisor and could be expected to be able to identify the nature and level of detail of the hazards required to be addressed.

3. The presence of asbestos was a well-known an obvious hazard in such projects. M Ltd was aware of the need for a full asbestos survey. It had been in breach of regulation 20 of the 2007 Regulations.

4. W had taken the view that there had been a lack of competence. The employment tribunal had found that the breach of regulation 20 was due to a systems failure rather than incompetence.

5. The tribunal had left it to the parties to agree the terms of a modified schedule to the improvement notice. It had been entitled to do so.

Limitation

Noise induced hearing loss

Platt v BRB (Residuary) Ltd [2015] PIQR P7, Court of Appeal

Statute reference: Limitation Act 1980, s.14(3)

P was employed by B from 1953 until 1988. He began to complain to his GP about his hearing in 1982. From then until 2011 he consulted doctors on 12 occasions. He was not

informed until 2011 that his hearing loss was noise induced. He had been referred to a specialist ENT Registrar in 1997 and was asked if he had worked in a noisy environment. He said that he had. He did not ask whether, and was not told that this was the cause of his hearing issues. He claimed compensation from B for noise-related hearing loss.

The High Court found as follows:

1. P did not have actual knowledge, for the purposes of the *Limitation Act 1980*, that there was a real possibility that his hearing problems were noise induced until he read a newspaper article in 2010, less than three years before the issue of proceedings.
2. In relation to constructive knowledge, an objective test would be applied. A reasonable man in P's position would have been curious as to the cause of his complaints. However, it was too harsh to deem him to have acquired constructive knowledge when he had consulted doctors on 12 separate occasions and had failed to question them about their judgment.
3. It was not reasonable to expect P to have questioned the ENT doctor about the cause of his deafness, or anyone else, before 2010.

B appealed to the Court of Appeal.

Decision

1. The appeal was allowed.

2. P had knowledge that his injury was significant by 1997 at the latest.

3. The real question was whether it would have been reasonable for P to have asked his doctor in 1997 about the cause of his deafness and tinnitus.

4. It was reasonable to expect P to have asked whether the history of noise exposure, discussed during the 1997 consultation, had caused or contributed to his symptoms.

5. The test for constructive knowledge was a demanding one. The fact that P had by then been retired for nine years and that he had multiple ear and hearing problems over the previous years did not make it unreasonable to expect him to be curious about the cause.

Manual handling

Sloan v The Governors of Rastrick High School (2014) Court of Appeal, July 29

Statute reference: Manual Handling Operations 1992

S was employed by GR as a learning support assistant. The school had a number of pupils who needed wheelchair use. S's duties involved pushing pupils in their wheelchairs between classrooms. In September 2008 she suffered pain in her shoulder after pushing a pupil in a wheelchair. She alleged that she had suffered a soft tissue injury in her spine and shoulder as a result of pushing wheelchairs. She claimed compensation for a breach of the Manual Handling Regulations, arguing that the school had failed to avoid the need for her to undertake a manual handling operation, that no risk assessment had been undertaken and that it had not taken steps to reduce the risk of injury. At first instance, her claim was dismissed.

The judge found that the strain which she had suffered in September 2008 had lasted two weeks and that any further symptoms had resulted from constitutional causes. Further, the school had not been in breach of the Regulations. S appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. The judge at first instance had misdirected herself as to the burden of proof under the regulations. The burden of proof was on the employer to prove that it had taken appropriate steps to reduce the risk of injury to the lowest level reasonably practicable. But this misdirection did not mean that the judgment should be set aside.

3. It had been alleged that the school should have supplied powered wheelchairs. In fact, the school had not provided wheelchairs: they had been supplied by the NHS or by pupils' parents. It had not been reasonably practicable to avoid the use of manual wheelchairs.

4. The school had prepared an annual risk assessment for each pupil who used a wheelchair. It was clear that the judge had found that the assessment complied with the 1992 Regulations.

5. The school had taken appropriate steps to reduce the risk of injury to the lowest level reasonably practicable.

Manual handling

Pattani v ICICI Bank UK plc [2014] EWHC 4356, QB

P was employed by I. She claimed damages of £1.5 million for personal injury allegedly suffered in 2007 and 2009 when she was required to undertake repeated lifting of heavy items which injured her back. She based her claim on a breach of the Manual Handling Operations Regulations 1992 and common law duties to protect its employees from injury and provide a safe system of work. I argued that P was engaged in clerical office work and any element of manual handling was so insignificant as to involve no real risk of injury or so small a risk that no practical precautions were necessary.

Decision

1. The tasks required of P did not involve heavy lifting or any lifting which involved a risk of injury.

2. P had failed to establish any breach of duty or causation.

3. The claim was dismissed.

Stress

Foreseeability

Easton v B&Q plc (2015) Morning Star, May 29, High Court

E was a senior store manager employed by B&Q. In February 2010 he was working 14 hours a day. He was diagnosed as suffering from depression. He went off sick and made two unsuccessful efforts to return to work. E complained that his illness had been caused by occupational stress resulting from the negligence of B&Q and its failure to carry put a risk assessment. He also claimed that the employer's failure to manage his return to work caused him to relapse.

Decision

1. E's breakdown had not been foreseeable because he had no history of psychiatric or psychological problems.

2. There was nothing about store managers in general which might give rise to foresight of such a risk.

3. The company had acted reasonably by offering E a phased return to work.

4. Even if B&Q had carried out a risk assessment, it would not have made any difference. The working environment in the company was no more pressured than in many similar organisations. The staff handbook made it clear that staff must talk to their manager about feeling stressed. He had not done this.

Vicarious liability

Graham v Commercial Bodyworks Ltd (2015) ICR 665, CA

G and W were colleagues employed by CB. W, as a prank, used a cigarette lighter in the vicinity of G, whose overalls he had sprinkled with a highly flammable thinning agent which was used at the premises. G's overalls burst into flame and he suffered serious injuries. G claimed compensation from CB on the basis of vicarious liability. At first instance the claim failed because W had not been acting in the course of his employment. G appealed to the Court of Appeal.

Decision

1. The appeal was dismissed.

2. The issue of vicarious liability depended on whether there was a close connection between the creation or enhancement of a risk and the wrong resulting from that risk.

3. The employer had created a risk by requiring employees to work with thinning agents but it was difficult to say that the creation of that risk was sufficiently closely connected with W's highly reckless act.

4. The real cause of the injury was the reckless conduct of W which could not be said to have occurred in the course of his employment.

Vicarious liability

Workplace health and safety

Wilkinson v Hjatland Housing Association Ltd (2015) Rep.L.R. 62

Statute reference: Workplace (Health, Safety and Welfare) Regulations 1992, regs. 4, 12; Occupiers' Liability (Scotland) Act 1960, s.2

W was a care worker employed by a local authority (L) to provide care for the tenants of H, at a housing development. As she was walking through the development's central courtyard in a snowstorm, she stepped into a hole left by the removal of a damaged water feature and was injured. She claimed compensation from H on the basis of breaches of the 1992 Regulations and the Act of 1960.

Decision

1. H was liable.

2. The courtyard was provided by H to L's employees as a place of work.

3. W had been in the courtyard in the course of her employment.

4. It was foreseeable that the area of the courtyard would be used as a shortcut.

5. H had control of the courtyard within the meaning of the 1992 Regulations.

6. H's failure to ensure that contractors had carried out repairs to the feature to the requisite standard amounted to a breach of the 1992 Regulations.

7. It was a mandatory requirement of regulation 12 of the 1992 Regulations that a traffic route should have no hole.

8. H was the occupier of the courtyard and had a duty to exercise reasonable care for the purposes of the 1960 Act.

9. H was liable for the actions of its agents if those actions were their own or those of their own employees. There was no basis for holding that H could escape liability by entrusting the work to independent contractors. It was reasonably foreseeable that a hole in the ground would not be obvious because of weather conditions. H had not taken any safety precautions.

10. There would be no deduction for contributory negligence. W had taken a shortcut which was not inherently dangerous. The existence of the hole was not obvious to her and she had no reason to take care for her own safety.

Work equipment

Coia v Portavardie Estates Ltd [2015] CSIH 3,Scottish Inner House

Statute reference: Provision and Use of Work Equipment Regulations 1988; Workplace (Health, Safety and Welfare) Regulations 1992

C, a chef employed by P, rented a lodge from P under an informal agreement which required C to clean it and to vacate it if it was needed for customers. P told C to vacate. As he was removing his belongings from a wardrobe, an unsecured pole in the wardrobe struck him, causing injuries. He claimed compensation from P. At first instance, the claim failed for the following reasons:

1. The pole was not work equipment.
2. C was not at work when he was in the lodge.
3. C had not been acting in the course of his employment when the incident happened.

C appealed.

Decision

The appeal was dismissed. The wardrobe was not in the lodge for use at work. It was not work equipment. There was no evidence that C was removing his possessions as a result of an instruction given to him in the course of his employment. The lodge was not a workplace.

Working abroad

Cassley v GMP Securities Europe LLP and Sundance Resources Limited (2015) EWHC 722

C, an employee of GMP, was killed in an air accident when travelling in an aircraft which was chartered by SR from a Congolese aviation company. SR had indicated that the flight involved a risk and asked GMP to waive liability for death or injury. SR did not sign the waiver and it therefore had no legal effect. C's dependants brought claims against GMP and SR for failing to adequately investigate the risk of the air travel and the use of local operators in poorly developed countries.

Decision

1. The employer had owed the deceased a common law duty of care to provide a safe place of work and had a non-delegable duty to take reasonable care to ensure that he was reasonably safe during his travels in the course of his employment.

2. Breach of those duties had not been causative of C's death. The flight had been a last-minute substitution and even if GMP had carried out reasonable investigations into the airline, these would not have revealed anything which would have resulted in the cancellation of the booking.

3. Further investigations would have revealed that the replacement charterer was recommended by other pilots and had all necessary licences and insurance.

4. The claim failed.

Working abroad

Dusek v Stormharbour Securities LLP (2015) EWHC 37

D, an employee of SH, was killed in a helicopter crash in Peru. The helicopter operator was local and had no record of previous accidents. D's dependants claimed compensation from SH.

Decision

1. The claim succeeded.

2. If SH had made safety checks it would have instructed its employee not to take the flight because of safety concerns.

3. Many of the factors relied upon by the employer were more relevant to what would have been learned if some safety checks had been made. This highlighted the need for some investigation to have been undertaken.

2014 Cases

Acetone burns

£5000 fine

Health and Safety Executive v Thames Cryogenics Ltd (2014) Oxford magistrates' court, March 3

Thames Cryogenics Ltd, a specialist manufacturer of vessels and pipework, has been fined following an incident in which a welder was seriously burned by acetone.

Significant points of the case:

- A welder employed by the company suffered serious burns to his left leg when an open bowl of acetone ignited as he used it to quench a hot workpiece.
- The acetone was intended to be used as a degreasing agent but welders used it for quenching purposes despite its highly flammable properties.
- The company did not consider the use of large quantities of acetone in an open container to be an issue.
- Three improvement notices were served on the company.

The company was fined £5000 plus £4500 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

Amputated finger

Conditional discharge

Health and Safety Executive v Birtenshaw (2014) Trafford magistrates' court, April 11

Birtenshaw, a charity, has been fined following an incident in which a child lost a finger.

Significant points of the case:

- In September 2012 a nine-year old pupil at the Birtenshaw special needs school in Bolton trapped his hand in the hinge of a door at the school's quiet room.

- The child, who is autistic and has learning difficulties, lost the whole of his index finger.
- The charity had identified the need for finger guards during the construction of the school. It failed to ensure that the guards had been fitted.

Birtenshaw was given a conditional discharge and ordered to pay £898 costs under section 3, HSW Act, for failing to ensure the health and safety of non-employees.

A spokesperson for the HSE commented after the case that the charity knew that there was a risk of children's fingers being trapped in doors. Pupils who attended the school had learning and physical disabilities which made them particularly vulnerable.

Amputated leg

£20,000 fine

Health and Safety Executive v Con Mech Engineers Ltd (2014) Peterlee magistrates' court, April 14

Con Mech Engineers Ltd has been fined following an incident in which a worker suffered serious leg injuries.

Significant points of the case:

- In January 2012 an agency worker engaged by Con Mech was working in the heat treatment process area of the company's site in Stanley,County Durham.
- He was struck between a moving vehicle and a water tank. He was trapped for alost and hour and his right leg was later amputated. His left leg also suffered severe crush injuries.
- The company had failed to assess and identify the risks posed to workers from contact with the moving vehicle. The vehicle ran on a fixed track, moving heavy components.

Con Mech was fined a total of £20,000 plus £8000 costs under section 2, HSW Act, for failing to ensure the health and safety of employees, and section 3, for failing to ensure the health and safety of non-employees.

Arm injuries

£24,000 fine

Health and Safety Executive v CEP Ceilings Ltd (2014) Stafford magistrates' court, March 12

CEP Ceilings Ltd has been fined after a worker suffered serious arm injuries when his arm was caught in machinery.

Significant points of the case:

- A worker at the company's premises in Stafford was removing hardened glue from a spindle on a laminator machine in January 2013.
- His forearm was caught in the intermeshing metal gears of the machine. He required a skin graft to heal the laceration.
- The covers which protected the drive mechanism had been removed to give easier access to the spindle.
- The company had not carried out a suitable and sufficient risk assessment. No safe system of work was in place and insufficient monitoring of employees had been carried out to identify unsafe practices.

CEP Ceilings was fined £24,000 plus £1100 costs under section 2, HSW Act, for failing to ensure the health and safety of employees, and for a breach of regulation 3 of the Management of Health and Safety at Work Regulations 1999, for failing to make a suitable and sufficient risk assessment.

Asbestos risk

£10,000 fine

Health and Safety Executive v Redwood Contractors Ltd (2014) Reading magistrates' court, May 8

Redwood Contractors Ltd, a building company, has been fined for failing to communicate a known asbestos risk.

Significant points of the case:

- Workers employed by Redwood were engaged in refurbishment work at a warehouse in Berkshire. They ripped out asbestos insulating board (AIB), thinking that it was asbestos cement.
- The company was in possession of a detailed asbestos survey which clearly identified the location of asbestos wall panels.
- This information was not communicated to workers on the ground. The material was removed without adequate control measures and protective equipment.
- AIB should only have been removed by a licensed asbestos contractor because of the risk of exposure to the dangerous fibres contained within it.
- The workers could have unwittingly inhaled asbestos fibres.

Redwood Contractors was fined £10,000 plus £2800 costs for two breaches of the *Control of Asbestos Regulations 2006* (CAR).

Regulation 5 of CAR states, in summary, that an employer shall not undertake work which is likely to expose employees to asbestos unless he has carried out a suitable and sufficient assessment as to whether asbestos is present.

Regulation 11 deals with the prevention or reduction of exposure to asbestos.

Breach of prohibition notice

£8000 fine

Health and Safety Executive v Eastlake Developments Ltd (2014) Cwmbran magistrates' court, April 25

Eastlake Developments Ltd has been fined for failing to comply with a prohibition notice.

Significant points of the case:

- In July 2013 Eastlake was engaged to install septic tanks in a six-metre deep excavation near Chepstow, South Wales.
- Following concerns raised about worker safety, an HSE inspector visited the site. He found significant failings. The excavation had unsupported sides and no barriers to prevent people falling in. The site manager had not been trained to manage excavations.
- The inspector served a prohibition notice to prevent further work taking place. Eastlake ignored the notice.

The company was fined £8000 plus £1110 costs under section 3, HSW Act, for failing to ensure the health and safety of non-employees, and for a breach of section 33, HSW Act, for contravening a requirement in a prohibition notice.

An HSE inspector commented after the case that failure to observe prohibition or improvement notices served by the HSE is a criminal offence and is taken very seriously by the courts.

Crushing death

£80,000 fine

Health and Safety Executive v Gerber Juice Company Ltd (2014) Newport Crown Court, May 16

Gerber Juice Company Ltd has been fined after an engineer was killed by falling pipework.

Significant points of the case:

- In June 2010 Gavin Bedford was dismantling pipework at the company's premises in Llantrisant, South Wales. The company had closed its factory in Llantrisant. The

deceased was one of a small team temporarily employed to work with specialist contractors in stripping the factory of its plant.

- The factory had become a construction site. The company planned, managed and monitored the project itself instead of appointing a competent principal contractor. The company had overlooked a number of hazardous jibs, including the removal of overhead industrial pipes and their supporting structures.
- The deceased's work had not been adequately planned, risk assessed, communicated or monitored by management. The safety systems which the company used to manage its specialist contractors had not been used to manage its own staff.
- No written plan had been provided to the deceased and his colleagues explaining how the structure was to be safely taken apart. Bolts and structural elements were removed in an unsafe sequence.
- A structure which weighed 300 kg fell on Bedford, causing fatal head injuries.
- The site's production manager was in charge of the decommissioning project despite never having received formal training, nor having done this type of work before.

The company was fined £80,000 plus £75,000 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

A spokesperson for the HSE is reported to have commented after the case that any demolition or dismantling work must be set down in writing and strictly monitored.

Crushing injuries

£20,000 fine

Health and Safety Executive v Marrill Ltd (2014) Gateshead magistrates' court, January 28

Marrill Ltd, an engineering company, has been fined following an incident in which a worker suffered severe crushing injuries in an unguarded machine.

Significant points of the case:

- In October 2012 an employee of Marrill, who wishes to remain anonymous, was told to repair a fault on a mechanical power press. The mechanism on the top of the press included a series of large toothed cogs, which were not guarded.
- The worker's right leg trailed over the cogs. The press operated and his right foot was dragged into the cogs. The lower part of his leg had to be amputated.
- There had been no guard on the cogs for two to three years before the incident.
- Despite employees having to work close to the danger area, the company had failed to properly assess the risks.
- Guards were available and easily fixed, but the company had failed to identify the risk and take appropriate action to repair and replace them.

The company was fined £20,000 plus £900 costs and a £100 victim surcharge. Revenue raised from the Victim Surcharge is used to fund victim services through the Victim and Witness General Fund.

Death caused by refuse vehicle

£20,000 fine

Crown Office and Procurator Fiscal Service v Glasgow City Council (2014) Glasgow Sheriff Court, April 11

Glasgow City Council has been fined following the death of a member of the public who was struck by a refuse vehicle.

Significant points of the case:

- Malcolm McCulloch, aged 71, was walking across a street in Glasgow when he was struck by a reversing refuse vehicle. He died from his injuries.
- The council had introduced a programme of reversing assistant training for the refuse vehicles. On the day of the incident, neither the driver of the vehicle nor his labourer assistant, had received this training. The driver was an agency worker.
- The council had failed to ensure that both workers received the training.
- When the vehicle was being reversed, using its flashing beacon and reversing siren, neither the driver nor his assistant saw Mr McCulloch crossing the road.
- There was a blind spot two metres wide which was not covered by the vehicle's wing mirrors. A reversing assistant should have been used to guide the driver and to prevent pedestrians from crossing the road while the vehicle was being reversed.

Glasgow City Council was fined £20,000 for a breach of section 3, HSW Act, for failing to ensure the health and safety of non-employees.

Death of apprentice

£75,000 fine

Health and Safety Executive v Tyne Slipway & Engineering Co Ltd (2014) Newcastle Crown Court, January 21.

Tyne Slipway & Engineering Co Ltd (TSECL) has been fined following the death of an apprentice.

Significant points of the case:

- In December 2011 Jason Burden, a 19 year-old apprentice engineer at TSECL, was reassembling a tunnel thruster from a ship at the company's site in Sunderland. The tunnel thruster was a gearbox and propeller used to manoeuvre a ship.

- The piece of machinery, which weighed almost one tonne, toppled onto him. He suffered fatal crushing injuries. The machinery was notionally stable but the company had not taken sufficient steps to ensure that it was safe to work on.
- The company had no documented risk assessment for working on the machine while it was positioned on a workbench. There was no documented safety management system for undertaking work on behalf of the thruster manufacturer.

TSECL was fined £75,000 plus £47,900 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

Death of firefighter

£75,000 fine

Health and Safety Executive v Kemble Air Services Ltd (2014) Gloucester Crown Court, May 13

Kemble Air Services Ltd (KAS), the company which operates Cotswold Airfield, has been fined following the death of a firefighter.

Significant points of the case

- In April 2011 Steven Mills, who was employed by KAS as Station Officer at the airfield, was also a retained firefighter employed by Wiltshire Fire and Rescue Service.
- He was working to clear out a number of disused shipping containers which were being prepared for use as a training facility for the airfield.
- A number of redundant gas cylinders, formerly part of a fire suppression system, had to be removed. The deceased was attempting to move a gas cylinder which weighed 65 kg. The gas in the cylinder discharged very rapidly and the cylinder spun round. It struck the deceased on his head and body, causing fatal injuries.
- KAS had not assessed or considered the risk in relation to the safe decommissioning of the fire suppression system. If the work had been adequately assessed and managed, the incident could have been avoided.

KAS was fined £75,000 plus £98,000 costs under regulation 3, Management of Health and Safety at Work Regulations for failing to make a suitable and sufficient risk assessment.

Farm fall

£12,500 fine

Health and Safety Executive v Nicholas Reed (2014) Colchester magistrates' court, June 3.

Nicholas Reed, trading as Bluegate Hall farm Partnership, has been fined following an incident in which a worker was seriously injured in a fall.

Significant points of the case

- In August 2013 a worker, who wishes to remain anonymous, was repairing a leak in the roof of a grain store at a farm in Stebbing, Essex.
- He fell four metres through fragile asbestos sheeting to the concrete floor below, suffering multiple fractures and lacerations.
- Nicholas Reed had failed to ensure that work on the roof was carried out safely. A purpose-built cage and ladder had been provided to access the roof but nothing was provided to prevent workers falling through the fragile material. There were no crawling boards or handrails available.

Nicholas Reed was fined £12,500 plus £3900 costs under regulation 9 (2) of the Work at Height Regulations 2005, for failing to ensure that work on a fragile surface was not properly protected.

An HSE inspector commented after the case that on average falls through fragile roofs cause seven fatal injuries every year. Simple, straightforward, common-sense procedures would have prevented this fall and the severe consequences for this worker. It was essential that the hazards associated with working at height were recognised and understood by those carrying out the work.

Foot and mouth experiment failings

£22,000 fine

Health and Safety Executive v Pirbright Institute (2014) City of London magistrates' court, April 30.

Significant points of the case:

- In November 2012 and January 2013 a ventilation system at the Pirbright Institute in Surrey, designed to create a negative pressure, was operated in a different configuration from normal.
- Such a facility would normally be maintained at differential negative pressures to ensure that air containing foot and mouth disease virus (FMDV) would be drawn from clean into dirty areas before being filter cleaned.
- Neither incident resulted in the release of FMDV to the outside environment. The HSE considered that the shortcomings in control, and non-compliance with licence conditions, were serious enough for legal action to be taken.
- Changes to operating procedures at the Institute must be properly planned, assessed and agreed in advance with the HSE and with DEFRA. This was not done. The Institute is required to maintain high levels of controls because of the highly contagious nature of FMDV if released.
- There was no effective alarm system to warn workers about the loss of negative air pressure.

The Pirbright Institute was fined £22,350 plus £50,000 costs for eight breaches of the Specified Animals Pathogens Order 2008. This was the first ever prosecution under the Order.

A Principal Specialist Inspector from the HSE's Biological Agents Unit commented after the case that at facilities where research is undertaken with foot and mouth disease virus, it is imperative that control measures are applied in a rigorous way. In common with other sites which pose major hazards, either to people or to the environment, there must be protection in depth. This involves having a number of protective measures, with each measure providing some degree of assurance in the event of other failures.

Forklift death

£140,000 fine

Health and Safety Executive v AAK UK Ltd (2014) Liverpool Crown Court, May 15

AAK UK Ltd, a sauces manufacturing company, has been fined following the death of a forklift truck driver.

Significant points of the case:

- In April 2011 Michael Moran, an employee of AAK, was driving a forklift truck at the company's factory in Runcorn.
- He was using the truck to load a lorry trailer outside the factory when another lorry reversed into the side of his vehicle. His truck overturned and he suffered fatal injuries.
- Forklift truck drivers regularly drove onto a public road to load lorries without the company putting safety measures in place.
- The deceased had been loading pallets onto the lorry trailer. He finished loading one side and moved into the road to reach its other side. As did so, a lorry started to slowly reverse. It struck the deceased's truck.
- Vehicles often visited the site with deliveries or to pick up loads for distribution. Most of them reversed down the public road.
- The company had not carried out an adequate risk assessment in relation to employees or visiting drivers. Drivers had not been given any information, training or instruction on how to load trailers safely. Supervision was poor.

AAK UK Ltd was fined £140,000 plus £22,000 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

An HSE inspector commented after the case that its inspection had revealed a chaotic and dangerous system It was entirely foreseeable that someone was at risk of being badly injured or killed.

Furnace valve death

£300,000 fine

Health and Safety Executive v AETC Ltd (2013) Leeds Crown Court, July 5

AETC Ltd, a specialist engineering company which manufactures products for the aerospace and power generation industries, and which is part of PCC Airfoils, an American company, has been fined following the death of an employee from head injuries.

Significant points of the case:

- In November 2009 Graham Britten, an employee of AETC, was carrying out maintenance work in a vacuum casting furnace at the company's site in Leeds. The main isolation valve closed suddenly and trapped his head, causing fatal injuries.
- The deceased had gone to a furnace to deal with a fault after the main isolation valve had become jammed. He was inspecting the valve when it closed.
- AETC did not have an effective isolation procedure for maintenance work on the furnace, had failed to act on repeated recommendations from their health and safety manager and had failed to adequately train and supervise maintenance staff.
- The lack of a consistent, monitored isolation policy resulted in there being no effective procedures in place to prevent Britten from entering the furnace without first isolating the equipment and releasing stored energy.
- The furnace control systems, intended to protect operators when carrying out routine cleaning work, were inadequate and exposed workers to unnecessary risk.

AETC was fined £300,000 plus £77,500 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

Gas explosion

£30,000 fine

Health and Safety Executive v Gaspack Services Ltd (2014) Cardiff Crown Court, March 31

Gaspack Services Ltd has been fined following the explosion of a gas cylinder.

Significant points of the case:

- In March 2010 Andrew Wright was filling a cylinder with nitrogen and carbon dioxide at the premises of Guardian Gas Ltd in Swansea.
- The cylinder exploded and severed his leg below the knee.
- The failed cylinder was one of a batch which Guardian Gas had sent to Gaspack, certified cylinder inspection body, for inspection, testing and certification for safe use for 10 years. The cylinders were certified by Gaspack as safe for use.

- The inspection should have included internal shot blasting to remove corrosion and a thorough internal check for cracks or flaws. Only 2/3/ of the cylinder had been shot blasted and there was a large crack near the top of the cylinder.
- An HSE examination of the arrangements at Gaspack discovered shortcomings in procedures, information, records, competency, supervision and monitoring.

Gaspack Services Ltd was fined £30,000 plus £60,000 costs for a breach of section 3, HSW Act, for failing to ensure the health and safety of non-employees.

Gas release

£24,000 fine

Crown Office and Procurator Fiscal Service v Fife Council (2014) Dunfermline Sheriff Court, May 1

Fife Council has been fined following the release of four tonnes of gas from an underground pipe.

Significant points of the case:

- In June 2010 drainage works were being carried out at the council's depot in Dunfermline by its employees. The workers were not supervised and they decided to excavate a new trench. They did not know that a decision had been taken not to excavate in that area.
- The workers used a hand held power tool and a mechanical digger. They exposed whinstone dust which is an indicator of the presence of gas pipes. They continued to excavate and ruptured a gas valve on a six-inch pressure main.
- One hundred properties and a primary school were evacuated.
- The council had failed to assess the risks to members of the public near the depot. It had also failed to provide and maintain a safe system of work for the excavation and had not provided necessary information, instruction and supervision for the excavation.

Fife Council was fined £24,000 for breaches of sections 2 and 3, HSW Act, for failing to ensure the health and safety of employees and non-employees.

General Motors fined for death of worker

Health and Safety Executive v General Motors UK Ltd (2013) Liverpool Crown Court, August 14.

General Motors UK Ltd, the owner of Vauxhall, has been fined following the death of a worker in a crushing incident.

Significant points of the case:

- In July 2010 Ian Heard, an employee of Vauxhall at its Birkenhead site, was working in the paint unit of the site. He entered part of the unit to try and free trolleys which had become stuck. The machine restarted and Heard suffered fatal crushing injuries.
- A doorway had been created through a wall at the back of the unit. This allowed access without the power being cut.
- A risk assessment had identified the potential danger posed by the door but no further action had been taken. It had become standard practice for workers to use the door to free stuck trolleys.

General Motors was fined £150,000 plus £19,000 costs for breaches of section 2, HSW Act and regulation 11 of the Provision and Use of Work Equipment Regulations 1998.

An HSE inspector commented that the company had now installed a new safety system on the door which meant that power to the machine had to be cut before the door could be opened. If this system had been in place in July 2010, Heard's life could have been saved.

Hand arm vibration

£10,000 fine

Health and Safety Executive v Babcock Flagship Ltd (2014) Truro magistrates' court, May 6

Babcock Flagship Ltd has been fined in relation to workers suffering permanent nereve damage from the use of vibrating tools.

Significant points of the case:

- Three employees of Babcock worked on maintenance of the grounds at HMS Raleigh in Torpoint, Cornwall.
- They were exposed to high levels of hand arm vibration caused by tools including hedge cutters and strimmers for extended periods which could amount to eight hours a day.
- The company knew that the workers had vibration-related conditions or health issues which could be aggravated by vibration. It had had health surveillance reports between 2009 and 2011. It had failed to put control measures in place.
- The workers were diagnosed with Hand Arm Vibration Syndrome or Carpal Tunnel Syndrome. The permanent damage caused to their health had a significant impact on their quality of life and ability to work.

The company was fined £10,000 plus £10,000 costs under regulations 5 and 6 of the Control of Vibration at Work Regulations 2005, for failing to make a suitable risk assessment and failing to eliminate or reduce the risk from exposure to vibration.

Hand arm vibration syndrome

£52,500 fine

Health and Safety Executive v Onesubsea UK Ltd (2013) Leeds Crown Court, December 16

Onesubsea UK Ltd, a company which makes valve assemblies, was fined after workers suffered hand arm vibration syndrome (HAVS).

Significant points of the case:

- Between 1999 and 2010 the company exposed workers to risks to their health and safety from the repeated use of hand-held power tools.
- 24 workers who had repeatedly used air guns, grinders, sanders, drills and torque wrenches were identified as suffering from HAVS. They had been given little or no health surveillance and no adequate remedial steps had been taken.
- The company had failed to properly assess the risks of using hand-held power tools, had failed to control known risks and failed to reduce vibration exposure.
- No ongoing health surveillance programme had been provided, and no adequate training or information on the safe use of tools had been provided.

The company was fined £52,500 plus £92,000 costs for a breach of section 2, HSW Act, for failing to ensure the health and safety of employees.

HAVS is a serious and disabling condition. Nearly two million people are reported to be at risk. Damage impacts on hand and finger dexterity and can trigger finger blanching attacks.

Hazardous chemical exposure: £10,000 fine

Health and Safety Executive v Marston Agricultural Services Ltd (2013) Grantham magistrates' court, October 14

Marston Agricultural Services Ltd, an agricultural machinery manufacturer, has been fined after employees were exposed to a hazardous chemical.

Significant points of the case:

- In June 2011 the HSE visited the company's site. Inspectors discovered that trailers were being sprayed with isocyanate-containing paint in large quantities.
- Spray booths were not properly maintained and were in poor condition. The booths were being used with the doors open. Parts of the trailers were in the workshop, which meant that there was potential for significant exposure to employees.
- Workers had been provided with personal protective equipment. However, overalls were ripped and gloves did not prevent chemicals infiltrating clothes and skin.
- Hygiene facilities were in an unhygienic condition and workers were reluctant to use them.
- An emergency shower was broken.

The company was fined £10,000 plus £13,000 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

An HSE inspector commented after the case that breathing in isocyanate paint mist could cause asthma. Paint sprayers were 80 times more likely to get asthma than the average worker. Continued exposure could lead to permanent and severe asthma for which there was no cure.

Hospital death

£200,000 fine

Health and Safety Executive v Mid Staffordshire NHS Foundation Trust (2014) Stafford Crown Court, April 28

Mid Staffordshire NHS Foundation Trust has been fined following the death of a patient.

Significant points of the case:

- Gillian Astbury, a 66 year-old Type 1 diabetic, died from diabetic ketoacidosis at Stafford Hospital in April 2011 because of failures to implement basic handover procedures and to ensure essential record keeping.
- Staff at the hospital did not follow or even sometimes look at medical notes which stated that Astbury needed insulin, regular blood tests and a special diet.
- The system for communicating patient needs at staff handovers was inconsistent. Record keeping and monitoring of patient care plans were far below acceptable standards.
- Mistakes were made at up to eight shift changes and 11 drugs rounds. The failure to administer insulin was the direct cause of Ms Astbury's death.

The HSE investigated the death in accordance with its policy to investigate health sector deaths where there was evidence that standards had not been met because of a systematic failure in management systems.

The Foundation Trust was fined £200,000 plus £27,000 costs for a breach of section 3, HSW Act, for failing to ensure the health and safety of non-employees.

Mid Staffordshire NHS Foundation Trust has been the subject of two major inquiries into events at Stafford Hospital between 2005 and 2009.

Illegal gas work

Suspended prison sentence

Health and Safety Executive v William Saint (2014) Colchester magistrates' court, May 1.

William Saint, an unregistered gas fitter, has been given a suspended sentence for carrying out illegal gas work.

Significant points of the case:

- William Saint was engaged to install a gas fired boiler to heat a swimming pool at a property in Brightlingsea. He was not registered with Gas Safe Register.
- The boiler failed to operate and was stated to be immediately dangerous following an inspection by British Gas.
- Saint received advice from a Gas Safe Register engineer but he failed to rectify the faults. The boiler was classified as at risk by Gas Safe Register.

Saint was sentenced to four months imprisonment, suspended for 12 months, and 150 hours of unpaid community work for three breaches of the *Gas Safety (Installation and Use) Regulations 1998* (GSIU), plus £850 costs.

Regulation 3(1) of GSIU states, in summary, that no person shall carry out work in relation to a gas fitting unless he is competent to do so.

Regulation 3 (3) states that no person shall carry out gas work unless he is a member of a class of persons approved by the HSE.

Regulation 27(1) states that no person shall install a gas appliance to any flue unless the flue is suitable and in a proper condition for the safe operation of the appliance.

Illegal supply of asbestos roofing panels

Prison sentence

Health and Safety Executive v Robert Marsh (2014) Worcester Crown Court, June 4.

Robert Marsh, sole director of RM Developments (2005) Ltd, has been sentenced to 12 months imprisonment for illegally supplying roofing panels containing asbestos.

Significant points of the case:

- Marsh supplied pre-used roofing sheets containing white asbestos to a farming partnership which was building a barn.
- The partnership agreed to pay £4000 for what it assumed would be substantial roofing material. Marsh supplied poor quality, second-hand roof panels for which he had paid nothing.
- A construction worker who had been roofing the barn fell through the fragile material and suffered fatal injuries.
- Following the fall, Marsh tried to persuade witnesses to hide the sheets and gave false information to the deceased's daughter. He later tried to persuade the deceased's relatives not to report the incident to the HSE.

Marsh was sentenced to 12 months imprisonment, disqualified from being a director for six years, and ordered to pay £10,000 costs, under section 37, HSW Act, and article 67(1), Registration, Evaluation and Authorisation of Chemicals (REACH) Regulations 2008, for placing a restricted article on the market.

A spokesperson for the HSE is reported to have commented after the case that asbestos fibres were a well-known and widely-publicised health risk and can lead to fatal illnesses. The supply of materials containing asbestos has been illegal for many years. Marsh demonstrated a complete disregard for the law for his financial gain. The weak second-hand panels which he supplied were a significant contributing factor to the death of the worker.

Mesothelioma

Causation

McDonald v National Grid Electricity Transmission plc [2014] UKSC 53

M worked as a lorry driver collecting loads of fuel ash from Battersea Power Station between 1955 and 1959. He had no direct contact with asbestos in the course of his work. He sometimes entered the power station and went into areas where asbestos dust was generated by lagging work. In 2012 he was diagnosed with mesothelioma. He died in 2014 and was represented by his widow. She claimed compensation for breaches of the Asbestos Industry Regulations 1931 and the Factories Act 1937, the legislation which applied during the period of his employment. The defendant (National Grid) was the successor to the occupier and operator of Battersea Power Station.

At first instance, the trial judge in Bristol dismissed the claims on the basis that his exposure to asbestos had been of a modest level and unlikely to pose any health risk. The defendant had submitted that M had not been employed by the occupier of the premises and that his main work was not directly involved with asbestos.

M appealed to the Court of Appeal. It was argued on his behalf that working with asbestos was a risk even if the work was occasional or for limited periods. The Court allowed the appeal under the 1931 Regulations but dismissed the appeal under the 1937 Act. The defendant and M appealed to the Supreme Court.

Decision

1. The occupier of a site is responsible under the Factories Act 1937 for all persons on the site. This responsibility is not limited to direct employees.

2. There was insufficient evidence to rebut the finding of the Court of Appeal that M had not established that a substantial quantity of dust was given off by the lagging process. There was no liability under the Act of 1937.

3. The Asbestos Industry Regulations 1931 applied to all premises using asbestos and was not limited to those dealing with it in a raw, unprocessed form. The Regulations were intended to address harm which could be caused by the manipulation of asbestos rather than focusing on any particular setting where it might take place.

4. A worker in a factory or workshop where the processing of asbestos takes place is within the scope of the 1931 Regulations even if he is not mixing asbestos himself or is directly employed by the occupiers of premises where that is taking place.

5. It was a fallacious argument to submit that liability depended on a substantial quantity of asbestos dust being inhaled.

6.The appeals were dismissed.

PPE manufacturer fined for unsafe machine

Health and Safety Executive v JSP Ltd (2014) Oxford magistrates' court, April 30

JSP Ltd, a company manufacturing personal protective equipment, has been fined after a worker suffered serious hand injuries in an unsafe machine.

Significant points of the case

- In January 2013 a worker at the company's site in Oxfordshire was stirring paint for a printing machine. Her hand was trapped in the machine. She sustained a broken knuckle and serious nerve damage.
- A micro switch on the interlocking sliding door guard on the machine had failed.
- The company had been using the machine for eight years without any incidents. The safety devices had not been checked or maintained throughout that period.

The company was fined £4000 plus £1000 costs under regulation 11 of the *Provision and Use of Work Equipment Regulations 1998* (PUWER) for failing to prevent access to the dangerous parts of a machine and failing to ensure that guards were maintained in an efficient state, efficient working order and good repair.

An HSE inspector commented after the case that employers need to avoid complacency. They cannot afford to assume that machines which have been running for some time are going to remain safe without regular checks of safety-critical devices.

Serious burn injuries

£10,000 fine

Health and Safety Executive v Dray Building Ltd (2014) Westminster magistrates' court, April 16

Dray Building Ltd has been fined after a worker suffered life-threatening burn injuries.

Significant points of the case:

- In August 2012 Vlatko Milenkov, an agency worker contracted by Dray, was working on a property in Westminster. He was removing electrical equipment when it exploded. He suffered severe burns to his arms, legs, body and face and was in an induced coma for two weeks.

- Milenkov had thought that the equipment was disconnected. One cable remained live and he drilled through it.
- Dray had failed to provide suitable signage for the live cable and had failed to provide barriers around the work equipment. The company's construction plans stated that services had to be identified and that any assessed as live should be marked. This had not been done.
- Contractors should be mindful of electrical risks during construction work, particularly during demolition and refurbishment.

Dray Building Ltd was fined £10,000 plus £9800 costs for a breach of regulation 34, Construction (Design and Management) Regulations 2007, which states in summary that where there is a risk from electric power cables, suitable warning notices and barriers suitable for excluding work equipment which is not needed shall be provided.

Serious crush injuries

£30,000 fine

Health and Safety Executive v Alloy Bodies Ltd (2013) Manchester Crown Court, December 9.

Alloy Bodies Ltd, a company which manufactures lorry trailers, has been fined after a worker suffered serious crush injuries.

Significant points of the case:

- In June 2010 an employee of the company, who wishes to remain anonymous, was working at its site in Manchester.
- The company's bespoke services department had built a two-metre fish tank, weighing 200 kg, for a director. The tank was being loaded into the back of a van when it fell and struck the employee. The tank had not been secured to a pallet before being lifted.
- The employee suffered two fractured legs. His right leg was amputated below the knee.

The company was fined £30,000 plus £56,000 costs for a breach of HSWA Act. An HSE inspector is reported to have commented after the case that this had been an entirely preventable incident. No effort had been made to plan the work in advance, despite it being a highly unusual activity. If the tank had been secured to a pallet and loaded onto a larger vehicle, the terrible injuries which the worker suffered could have been avoided.

Serious crushing injuries

£10,000 fine

Crown Office and Procurator Fiscal Service v Specialist Castings Ltd (2014) Falkirk Sheriff Court, April 23.

Specialist Castings Ltd has been fined following an incident in which an employee suffered severe crushing injuries.

Significant points of the case:

- Robert Easton was employed by Specialist castings as a moulder at its foundry in Stirlingshire. He was preparing a two-part mould, each half of which weighed one tonne, using an overhead crane.
- A casting box struck him below the knees, crushing his legs between the casting box and a cast iron platform. He suffered multiple fractures to his legs and ankle.
- The company had risk assessments in relation to operations at the foundry but nothing dealt specifically with the risks associated with turning moulds. There was no safe system of work setting out the correct method of carrying out the task.
- The company relied on the experience of its employees. No training was provided which was specific to the task of turning casting moulds.
- Easton had been involved in a previous incident at the foundry when he was injured while lifting a sand mould. Following this incident, the HSE advised the company in relation to providing additional training and supervision.

Specialist Castings Ltd was fined £10,000 for a breach of section 2, HSW Act, for failing to ensure the health and safety of employees.

Serious hand injuries

£17,000 fine

Health and Safety Executive v Sika Ltd (2014) Watford magistrates' court, March 14

Sika Ltd, a manufacturing company based in Welwyn Garden City, has been fined after an agency worker suffered a hand injury.

Significant points of the case

- The worker, who wishes to remain anonymous, was clearing a blockage on a palletiser machine at the firm's site in October 2012. As he restarted the machine, his right hand was struck by a moving part. He suffered multiple fractures and lacerations.
- The worker had bypassed an interlocked gate to clean the machine. This was common practice by employees.
- The machine guarding was inadequate to prevent access to dangerous parts of the machine.

- The company had failed to properly assess the risks from using the machine and had provided inadequate training, instruction and supervision.

Sika Ltd was fined £17,000 plus £1200 under section 2, HSW Act, for failing to ensure the health and safety of employees, and section 3, HSW Act, for failing to ensure the health and safety of non-employees.

Severe crushing injuries

£10,000 fine

Crown Office and Procurator Fiscal Service v Angus Tyres Ltd (2014) Arbroath Sheriff Court, April 15

Angus Tyres Ltd has been fined after an employee suffered severe crushing injuries.

Significant points of the case:

- In November 2012 Michael Davidson, an employee of Angus Tyres, was working on a farm, replacing the wheels of a tractor. He removed the nuts from one of the wheels when he noticed a farm labourer who might be injured if the wheel fell on him.
- The wheel toppled. Davidson managed to prevent it striking the labourer but it struck him. He suffered a collapsed lung and multiple fractures.
- Neither a risk assessment nor a manual handling assessment had been prepared for the changing of tractor wheels. The company had failed to enquire with the customer at the farm to ascertain the weight of the tractor wheels.
- There was no safe system of work for changing the wheels. No training had been given to employees for the work. Workers were left to change wheels alone without considering the weights to be handled by a single person.

The company was fined £10,000 under section 2, HSW Act, for failing to ensure the health and safety of employees.

Severe hand injuries

£6000 fine

Health and Safety Executive v Elite Composite Products Ltd (2014) Peterlee magistrates' court, May 6

Elite Composite Products Ltd has been fined after an employee suffered serious hand injuries in an inadequately guarded machine.

Significant points of the case:

- In September 2012 an employee of Elite, who wishes to remain anonymous, was cleaning the rollers of a glue rolling machine at its site in County Durham.

- He lifted a hinged guard to gain access to the rollers. His right hand was drawn into the rollers. He suffered stripped skin from his hand and damage to his wrist.
- The guard covering the rollers was connected to an interlocking safety device which was designed to stop the rollers turning when the guard was raised. The device was broken and the rollers did not stop.
- The company did not have adequate maintenance and safety check systems in place. These would have identified the broken device.

The company was fined £6000 plus £3100 under section 2, HSW Act, for failing to ensure the health and safety of employees.

Severed hand

£2000 fine

Health and Safety Executive v Marshall Brass (2013) Norwich Crown Court, November 4

Marshall Brass has been fined after a worker suffered a severed hand in a polishing lathe.

Significant points of the case:

- In February 2012 Gavin Nobes was working at the firm's site in Heckingham, Norfolk. He was polishing a brass clock face bezel on a lathe. The bezel snagged on a polishing wheel and drew his hand and arm into the machine.
- His left hand was severed and had to be reattached.
- The polishing lathe was not suitable for polishing the bezel because there was a high risk of snagging.
- The firm was prosecuted for failing to arrange an alternative method of polishing the bezel or adapting the machine or work system so that the work could be safely done.

The firm was fined £2000 plus £20,000 costs under regulation 4(1) of the Provision and Use of Work Equipment Regulations 1998 (PUWER).

A spokesperson for the HSE commented after the prosecution that duty holders need to carefully consider whether a particular job presents risks not normally encountered in more routine day-to-day activity, and make the necessary adjustments to ensure that there is a safe system of work in place.

Silicosis

£100,000 fine

Health and Safety Executive v Stonyhurst College (2014) Preston Crown Court, May 29

Stonyhurst College has been fined £100,000 after a stonemason developed silicosis.

Significant points of the case

- A stonemason was employed by the College for 12 years and was exposed to high levels of silica dust in the course of his work. In July 2011 he was diagnosed with silicosis.
- He and other stone masons were exposed to more than 80 time the daily limit for silica dust.
- His work involved intensive work with powered hand tools cutting, shaping, chiselling and finishing sandstone.
- The College had failed to take any measures to monitor or reduce the exposure of workers to silica dust, despite the sandstone containing between 70 and 90 per cent of crystalline silica.
- No equipment had been used to remove, capture or suppress the dust created by the tools.
- The stonemason suffered serious and irreversible health effects. He has a reduced lung function, suffers from breathlessness and can no longer work as a stonemason.

Stonyhurst College was fined £100,000 plus £31,000 costs for a breach of section 2, HSW Act, for faioing to ensure the health and safety of employees.

A spokesperson for the HSE is reported to have commented after the case that there had been no attempt by the College to assess and manage its employees' exposure despite having had its attention drawn to the risks by its own health and safety consultant in 2008.

Summerhouse fall

£5000 fine

Health and Safety Executive v Garden Affairs Ltd (2014) Bournemouth magistrates' court, April 30

Garden Affairs Ltd has been fined following an incident in which an employee sustained serious injuries in a fall.

Significant points of the case:

- In October 2013 an employee of Garden Affairs was helping to construct a large wooden summerhouse in a private garden in Christchurch, Dorset.
- He stepped from a tower scaffold onto the roof of the structure. The scaffold slipped and he fell two metres to the ground. He suffered fractures of is vertebrae, multiple bruising and impact injuries.
- Garden Affairs had failed to put any fall prevention or fall mitigation measures in place. Handrails had not been fitted to the tower scaffold, which was not tied to the structure for stability

The company was fined £5000 plus £468 costs and £750 compensation under regulation 4, Work at Height Regulations, which states, in summary, that employers must ensure that work at height is carried out in a manner which is, so far as is reasonably practicable, safe, so as to prevent the fall of any person whilst engaged in work on the roof of a structure.

Unguarded machine

£1000 fine

Health and Safety Executive v P & D Group Services Ltd (2014) Dudley magistrates' court, April 23.

P & D Group Services Ltd, a company which manufactures roller shutters, has been fined following an incident in which an employee severed part of his finger in an unguarded machine.

Significant points of the case:

- In September 2013 an employee of the company, who wishes to remain anonymous, was operating a rolling mill which folded flat metal strips into hollow tubes.
- He investigated a problem with the mill when his glove was caught and his finger was pulled into the roller. He suffered severe crush injuries and the top of one of his fingers was amputated.

The company was fined £1000 plus £1400 costs under regulation 11, Provision and Use of Work Equipment Regulations 1998 for preventing access to a dangerous part of machinery.

An HSE inspector made the following points after the case:

- Lack of guarding had persisted over a period of time which meant that there was an inevitability of someone being injured at some point.
- It was the company's responsibility to ensure that work equipment was safe and that dangerous moving parts were guarded.
- The company required employees to approach the danger area around the rollers to set up and adjust the machine during production runs yet continuously failed to identify and address the issue of the missing guards.

Unguarded machinery

£18,000 fine

Health and Safety Executive v E-Leather Ltd (2014) Peterborough magistrates' court, April 30

E-Leather Ltd has been fined after a female Polish employee suffered a hand injury in unguarded machinery.

Significant points of the case:

- In October 2012 the employee, who wishes to remain anonymous, was attempting to clear material from a leather buffing machine at the company's site in Peterborough.
- The employee restarted the feed roller of the machine. Her fingers were drawn into the machine and she suffered a broken index finger.
- There were no protective guards around the rotating parts of the machine.
- The company was convicted of an offence involving machinery safety failings in September 2010.

E-Leather Ltd was fined a total of £18,480 plus £1100 costs under regulation 11 of PUWER and regulation 3 of the *Management of Health and Safety at Work Regulations 1999*.

An HSE inspector commented after the case that the company's inadequate understanding of risk meant that its workers were exposed to the dangerous moving parts of the machine. A simple guard would have prevented the worker's painful injury.

Unsafe roofing work

£7500 fine

Health and Safety Executive v GS Roofing Specialists LLP (2014) Sandwell magistrates' court, April 28

GS Roofing Specialists has been fined following unsafe work at height.

Significant points of the case:

- In September 2013 an HSE inspector was visiting an industrial estate in West Bromwich. He observed two workers on the fragile roof of a business unit. They were working on the roof without adequate fall prevention or fall mitigation measures in place.
- The company had prepared a risk assessment and method statement for the work which stated that guard rails and netting would be used. This was not done.

The company was fined £7500 plus £1000 costs under regulation 9(2), Work at Height Regulations 2005. This regulation states, in summary, that where work is being carried out on a fragile surface, every employer shall ensure that suitable means of support or protection are provided.

In 2013 more than 6300 employees suffered major injuries after falling from height at work. Working on roofs accounts for almost a quarter of all workers who are killed in falls from heights.

Wall collapse

£140 fine

Health and Safety Executive v Lee Marsden (2014) Kirklees magistrates' court, April 9

Lee Marsden, director of MWK Group LLP, a building company, has been fined after a 61-yer old woman suffered multiple injuries when a garden wall collapsed.

Significant points of the case:

- In September 2011 a woman, who wishes to remain anonymous, was seriously injured when a wall collapsed in her garden.
- Marsden had failed to ensure that the wall was properly built to withstand the pressures of an earth-retaining structure.
- During the construction of the wall, in which Marsden was directly involved, cracks began to appear. Adequate precautions were not taken to ensure the safety of residents in the house.
- The woman was struck by the collapse of the two-metre wall. She suffered fractures and lacerations.

Marsden was fined £140 plus £100 costs under section 37, HSW Act, which states, in summary, that where an offence by a company has been attributable to a director of the company, he as well as the company shall be guilty of that offence.

2013 Cases

Bristol gas explosion

£30,000 fine

Health and Safety Executive v Calor Gas [2013] North Somerset magistrates' court, March 21.

Calor Gas has been fined after two workers suffered severe burns when they were caught in a gas explosion. In June 2010 Kevin Bates and Graham Crouch were carrying out a routine inspection of LPG gas tanks at a quarry in Flax Bourton, near Bristol.

They were using specialised equipment on the back of a covered lorry to remove residual gas from one of the tanks. The gas was piped into a slops tank on the back of the vehicle and a pressure relief valve was fitted to allow excess gas to escape harmlessly into the atmosphere. The two workers had not fully removed a tarpaulin which covered the valve. This allowed gas to build up under the cover on the back of the truck. They were in a special cab attached to the back of the truck. As they left the cab, the gas exploded. They suffered severe burns.

Decision

1. Calor Gas had failed to provide clear and adequate instructions about removal of the tarpaulin and should have provided more detailed training for workers.

2. The company was fined £30,000 plus £75,000 costs for breaches of section 2 of the Health and Safety at Work, etc., Act 1974, for failing to ensure the health and safety of employees, and section 3 of the same Act for failing to ensure the health and safety of non-employees.

Crushing injury

£6000 fine

Health and Safety Executive v THS Industrial Textiles Ltd (2013) Halifax magistrates' court, April 26.

THS Industrial Textiles Ltd has been fined following an incident in which a young worker suffered serious crushing injuries.

Significant points of the case:

- An 18 year-old warehouse worker employed by THS was working at the company's site in Elland, West Yorkshire.
- He was inside a container, unloading pallets, when a double-stacked pallet fell over and crushed him, causing a fractured leg. The company had operated a dangerous system of work for unloading the pallets for a significant amount of time and had failed to provide workers with the right equipment to do the job safely.
- The pallets were being dragged by workers, using straps, across the container floor to get them closer to its doors so that they could be lifted off by a forklift truck. The pallets were also dragged onto the end of the forks. The forklift truck was carrying pallets which exceeded its capacity.
- The company had been warned before the incident that the forklift was being used to lift loads which were too heavy. The warning was ignored.

The company was fined £6000 plus £4900 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

Death by crushing

£350,000 fines

Health and Safety Executive v BAE Systems (Operations) Ltd (2013) Hull Crown Court, May 21.

BAE Systems has been fined after an employee was crushed to death.

Significant points of the case:

- In November 2008 Gary Whiting, an employee of BAE, was working at the company's site in East Yorkshire.

- He was carrying out routine maintenance on a large metal press. He entered the machine to remove a piece of equipment. A colleague started the full test cycle of the machine and the press frame descended on Whiting. He suffered fatal crush injuries.
- Safety failings discovered by the HSE investigation included the absence of a suitable risk assessment and a lack of engineering control measures to prevent entry by workers to dangerous parts of the machine during testing or to stop the machine if a worker entered the danger zone. The guarding was inadequate and there were no key safety systems, no light guards or interlocks on the doors of the machine.

The company was fined £250,000 plus £97,000 costs under section 2, HSW Act, for failing to ensure the health and safety of employees.

Death from toxic fumes

£20,000 fine

Health and Safety Executive v Multicrest Ltd (2013) Southwark Crown Court, May 23.

Multicrest Ltd, a bath restoration company, has been fined following the death of an employee who inhaled toxic fumes.

Significant points of the case:

- In June 2009 Colin Pocock, an employee of Multicrest, was stripping a resin coating from a bath in the bathroom of a property in Wandsworth, South London.
- He was using a stripping agent which contained dichloromethane, a carcinogenic toxic chemical. Fumes accumulated in the confined space and Pocock died.
- There was insufficient natural ventilation in the bathroom. Multicrest should have provided mechanical ventilation equipment. The company had written documentation which stated that work of this nature should only be done in well-ventilated areas. No equipment had been provided to employees. Managers were not aware of how work should be done in bathrooms. They had failed to provide adequate safe working arrangements.

Multicrest was fined £20,000 plus £21,000 costs for a breach of section 2, HSW Act, for failing to ensure the health and safety of employees.

Death of lift engineer

£100,000 fine

Health and Safety Executive v ThyssenKrupp Elevator UK Ltd (2013) Southwark Crown Court, April 15.

ThyssenKrupp Elevator UK Ltd has been fined following the death of a lift engineer from an electric shock.

Significant points of the case:

- In October 2010 Steven Loake was trying to deal with a fault on the chapel lift at Pentonville prison. He did not isolate the lift from the power supply and suffered fatal injuries.
- The cause of the incident was that Loake came into contact simultaneously with a live conductor and metal parts of the lift structure. This created a path to earth and gave him an electric shock.
- The multimeter provided to Loake was not maintained in good repair. Its insulation had been stripped back, exposing an excessive amount of metal. This caused an increased risk of shock and burns.
- ThyssenKrupp, the maintenance contractor for all prison lifts in the UK, had failed to provide a safe system of work for its engineers. They were required to carry out work on live electrical systems.
- The company had also not provided adequate information and instruction related to work on electrical systems.

The company was fined £100,000 plus £25,700 costs for breaches of section 2, HSW Act and regulation 5(1) of the *Provision and Use of Work Equipment Regulations 1998*, for failing to ensure that work equipment was maintained in an efficient state, in efficient working order and good repair.

Death of locomotive driver

UK Coal fined £300,000

Health and Safety Executive v UK Coal Mining Ltd (2013) Nottingham Crown Court, April 15.

UK Coal Mining Ltd has been fined after an employee suffered fatal injuries in the workplace.

Significant points of the case:

- In July 2009 John Harbron, a locomotive driver, was working underground at Thoresby Colliery in Nottinghamshire.
- He was unloading a pack of steel pipes from a rail car. As he cut the plastic bands securing them, they rolled sideways and crushed him. He suffered fatal injuries.
- Each pipe was 13 feet long and weighed more than 11 stones.
- The pipe racks could not sit evenly on the type of rail car being used and could become unstable on the rail track, which tilted.

- There had been at least four written reports by locomotive drivers of pipe packs becoming unstable while being made ready for manual loading. Managers had failed to act on drivers' concerns.

UK Coal Mining Ltd was fined £125,000 plus £175,000 costs for breaches of sections 2 and 3, HSW Act, for failing to ensure the health and safety of employees and non-employees.

Fall death

Company and director fined

Crown Prosecution Service v North Eastern Maritime Offshore Cluster Ltd and others (2013) Newcastle Crown Court, May 21.

North Eastern Maritime Offshore Cluster Ltd (NEMOC) and one of its directors have been fined after a worker was killed in a fall.

Significant points of the case:

- In December 2008 Ken Joyce was working for Allan Turnbull, trading as A&H Site Line Boring and Machining, at the Swan Hunter Shipyard in Newcastle. He was dismantling structural steelwork of a roof.
- Joyce was working from a cherry picker. Colleagues were using a crane to lower steel beams. A beam struck the cherry picker and Joyce fell to the ground. He suffered fatal injuries.
- NEMOC had subcontracted the dismantling work to Turnbull. NEMOC and Christopher Taylor, its director, had failed to ensure the safety of its employees and subcontractors by not checking that Turnbull had the required competence to carry out the work.
- Turnbull had failed to adequately plan the work. He was sentenced to three years imprisonment for gross negligence manslaughter and offences under sections 2 and 3, HSW Act.

NEMOC, now in liquidation, was fined £1 under sections 2 and 3, HSW Act.

Christopher Taylor was fined £30,000 plus £50,000 for breaches of sections 2 and 3, HSW Act.

Farm tractor death

£80,000 fine

Health and Safety Executive v J & E Montgomery Ltd (2013) Bristol Crown Court, June 18

J & E Montgomery Ltd, a farming company, has been fined in relation to the death of a young farm worker in a tractor incident.

Significant points of the case:

- In June 2009 Kim Webb, an employee of Montgomery, was working on a farm near North Cadbury in Somerset. She was driving a tractor on a sloping field. The tractor had no seat belt, cab or roll over bar.
- Webb was checking cattle in a number of fields. The tractor rolled over twice and crushed Webb, causing fatal injuries.
- The tractor had no rollover protection. Brake pedals on the tractor could not be linked together. This made it unsuitable for road driving.
- There was a lack of suitable and sufficient risk assessments for the type of work being carried out.
- There was no safe system of work for the tasks which employees were required to carry out using the tractor.
- No effective training had been provided.
- There had been a failure of management control, oversight and supervision in relation to use of the tractor.
- Webb's supervisor had no formal training qualifications to instruct her in the use of the tractor.
- The company had allowed the tractor to be used without a roll bar and had failed to monitor the use of the tractor in a sloping field.

The company was fined £80,000 plus £40,000 costs for a breach of section 2 of the Health and Safety at Work, etc., Act 1974, for failing to ensure the health and safety of employees.

A spokesperson for the HSE is reported to have commented after the case that the tragic incident highlighted once again the dangers involved in agriculture. Between 40 and 50 workers are killed on British farms every year. That is nearly one person per week, which is a higher death rate than construction or manufacturing.

Runaway lorry death

Two companies fined

Health and Safety Executive v Larkins Logistics Ltd and Bison Manufacturing Ltd {2013} Derby Crown Court, April 24.

Larkins Logistics Ltd, a haulage company, and Bison Manufacturing Ltd have been fined after a worker was killed by a runaway lorry.

Significant points of the case

- In October 2010 Gary Walters, an employee of Larkins, was collecting a trailer of structural concrete products from Bison. He did not apply the brake to his cab. Bison's drivers had not applied the brake to the trailer and the vehicle moved off.
- Walters was struck by the vehicle and suffered fatal injuries.
- Drivers working for Bison routinely failed to apply the brakes to the trailers. There had been a number of other examples of lorries rolling away and Larkins' drivers had not been properly trained in the use of trailer brakes.
- Larkins and Bison had identified the risks to workers but had not implemented appropriate control measures. Their working practices ignored published safety guidance.

Larkins was fined a total of £450,000 for offences under sections 2 and 3, HSW Act.

Bison was fined a total of £300,000 for the same offences.

Serious fall injuries

£1000 fine

Health and Safety Executive v O'Brien (2013) Nuneaton magistrates' court, April 11.

John O'Brien, a self-employed roofer, has been fined following an incident in which an employee fell through a skylight.

Significant points of the case:

- In July 2010 an employee of O'Brien was recladding a roof at industrial premises in Nuneaton. He fell seven metres to the ground through a fragile skylight and suffered serious injuries.
- O'Brien had taken some steps to protect workers on the roof but there was no protection in place on the skylight, which was known to be fragile.
- Metallic mesh had been placed under the roof to catch a falling person but there was no covering over the skylight.

O'Brien was fined £1000 plus £1000 costs for a breach of regulation 9 of the *Work at Height Regulations 2005*. This regulation states, in summary, that where workers are passing or working from or near a fragile surface, suitable and sufficient means of support or protection must be provided.

Serious farm injury

£3000 fine

Health and Safety Executive v David Barron (2013) Consett magistrates' court, May 28.

David Barron, a farmer, has been fined after a colleague suffered serious injuries during farm work.

Significant points of the case:

- In July 2011 Leonard Laxton was helping, as a favour, his friend David Barron on Barron's farm.
- The two men were removing roof sheets and carrying them across the roof to the edge, using scaffold boards as a tightrope to prevent them from stepping onto fragile roof material.
- Laxton fell from a scaffolding board onto the roof. It collapsed and he fell four metres. He suffered a fractured spine and ribs.
- The measures in place to prevent a fall through the roof were wholly insufficient. There was nothing in place to prevent workers on the roof from falling from its edge.

Barron was fined £3000 plus £4000 costs under section 3, HSW Act, for failing to ensure the health and safety of non-employees.

A spokesperson for the HSE is reported to have commented after the case that deaths in agriculture were often caused by fragile roofs and advice on precautions to prevent or reduce the risk from falls when working at height.

Severed fingers

Company and director fined

Health and Safety Executive v JSF Stainless Ltd and Richard Lancaster (2013) April 18, Walsall magistrates' court.

JSF Stainless Ltd, a steel products manufacturer, and its director, have been fined following an incident in which a 17 year-old worker suffered severed fingers on a moving saw blade.

Significant points of the case:

- In June 2011 the young worker, who wishes to remain anonymous, was asked by Lancaster to clean a steel cutting saw while the blade was still moving.
- He had never before used the machine and did not know how to stop the blade. The saw caught his left hand and severed three fingers and his thumb.
- The young worker should never have been instructed to clean dangerous equipment which was still in operation. He should have been provided with appropriate training on how to make the machine safe to clean and should have been suitably supervised.

JSF Stainless Steel Ltd was fined £6000 plus £13,000 costs under section 2, HSW Act.

Richard Lancaster was fined £2000 for the same offence, plus £2600 costs.