Contractor prosecuted after spot check reveals multiple breaches

A construction contractor has been fined after multiple health and safety issues were identified during a proactive Covid spot check at a site in Manchester.

Manchester Magistrates' Court heard that on 9 July 2020, a HSE inspector performed a proactive Covid-19 spot check at a construction site in the city.

During the inspection, a host of safety issues were identified including working at height, welfare, Covid-19, site security, and electricity. The principal contractor was served with a Prohibition Notice and two Improvement Notices.

A return inspection was made on the 17 August 2020, after very little communication from the principal contractor. Little or no improvements had been made regarding the issues and additional enforcement action was required, including a further Prohibition Notice regarding an unsupported excavation.

It was subsequently established that the contractor had failed to comply with any of the Improvement Notices HSE had served.

Principal contractor Umar Akram Khatab, now resident in Hollingwood Lane, Bradford, pleaded guilty to breaches of Section 21 of the Health & Safety at Work etc. Act 1974 and Regulation 13(1) of the Construction (Design and Management) Regulations 2015. He was sentenced to a 12-month community order. He was also ordered to pay £3,000 towards costs and a victim surcharge of £95.

Speaking after the hearing, HSE inspector Rebecca Vaudrey said: "HSE prides itself on being a proportionate and evidence-based regulator. Since the beginning of the pandemic HSE has carried out more than 316,000 Covid spot checks, with the priority to urgently make workplaces safe from transmission risks, rather than heavy-handed enforcement.

"These checks have demonstrated that the majority of employers want to do the right thing to ensure their workers go home safe and well.

"This is the first prosecution to arise from the Spot Check programme. We've repeatedly stressed that prosecution is a last resort, but this case clearly illustrates that where there is consistent disregard to Covid or other risks to employees' health and safety, HSE will use its powers to take action."

Notes to Editors:

1. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. We prevent work-related death, injury and ill health through regulatory actions that range from influencing

behaviours across whole industry sectors through to targeted interventions on individual businesses. These activities are supported by globally recognised scientific expertise. hse.gov.uk
2. More about the legislation referred to in this case can be found at: Construction – Health and safety for the construction industry (hse.gov.uk)
3. HSE news releases are available at http://press.hse.gov.uk

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Recycling company fined for poor health and safety management

A waste and recycling company has been fined after HSE inspectors discovered widespread poor management of health and safety risks at their site in West Drayton, London.

Westminster Magistrates Court heard that, on 21 March 2019, inspectors attended Iver Recycling (UK) Limited, Holloway Lane, West Drayton, to carry out a routine inspection, where they discovered widespread risk to employees and poor health and safety management of the site.

HSE revisited the site on 1 April 2019 with electrical engineering, mechanical engineering and civil engineering specialists to assess the site. In total, HSE issued nine Prohibition Notices and seven Improvement Notices. Conditions were so bad that an investigation was conducted to help understand the underlying causes of the conditions seen. The investigation concluded that a lack of competent advice, risk assessment and poor management had led to deterioration of conditions on site, despite previous enforcement being issued by HSE.

Iver Recycling (UK) Limited failed to appear at the hearing on 16 September 2021, and the case was heard in their absence. The court found that HSE's case, a breach of Health and Safety at Work etc. Act 1974 Section 2(1) had been proved. The company were issued with a £200,000 fine and order to pay cost of £7,125.72 and the victim surcharge of £170.

Following the hearing, HSE inspector Sarah Pearce said: "Companies should be aware that if they fail to operate their businesses in a manner which protects the health and safety of those who work there, HSE will pursue those responsible to the highest possible level. The conditions seen at this site

should not occur in 21st-century Britain.”

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2. More about the legislation referred to in this case can be found at: legislation.gov.uk/ [2]
3. HSE news releases are available at http://press.hse.gov.uk[3]

Chemical company fined £1million for fatal explosion

Chemical company, Briar Chemicals Ltd, has been fined £1million after a man died in an explosion at its site in Sweet Briar Road, Norwich.

Chelmsford Magistrates Court heard how on the 27 July 2018, maintenance contractor, Rob Cranston, aged 46, was carrying out repair work on a mixing vessel during a planned period of shutdown maintenance. It is thought that his welding torch or grinder accidentally ignited flammable Toluene vapour inside the vessel which should not have been present when the work commenced. Mr Cranston’s son Owen, aged 22, was working alongside his father when Mr Cranston was killed in the blast.

The HSE investigation found that a quantity of Toluene residue had been left inside the vessel after shutdown cleaning at the beginning of June 2018. Two damaged valves situated above the vessel in the Toluene supply pipe, were also found to be leaking. Operatives had been instructed to transfer a large

quantity of Toluene from one storage tank to another via this pipe which allowed additional flammable liquid to leak into the vessel which was supposed to be empty and clean.

In a Victim Impact Statement read out in court, Mr Cranston's widow, Claire, said:

"We married on 16 August 2003; he would have been 50 years old this year. He was so well-known and liked. I had his funeral at the Norwich Cathedral, there were over 750 people in attendance.

"This has obviously been horrendous for both our sons, particularly Owen having to deal with actually being there at the time. Our lives changed forever that day. We will never forget him and are only left wondering what the future would have held for us all together. We were still young enough to have had years of happiness ahead. He will miss seeing our sons' lives develop and grandchildren in years to come."

Briar Chemicals Ltd failed to take all necessary measures to prevent the explosion and pleaded guilty to a breach of Regulation 5 of the COMAH Regulations 2015. The company was fined £1million and ordered to pay costs of £10,967.20.

Speaking after the hearing, HSE inspector Mrs F Bailey, who led the three-year investigation, commented:

"This was a complex and highly technical investigation, due to the chemical hazards on site and the number of underlying issues which combined to cause the explosion. HSE hope that this case helps to communicate important safety messages to wider industry so that other fires and explosions are prevented in future.

"Any company handling or storing flammables should consider the potential risk of fire and explosion and ensure they have robust procedures in place to minimise and control risk at all times, including during planned maintenance work."

Notes to editors

1. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. We prevent work-related death, injury and ill health. It does so through research, information and advice, promoting training; new or revised regulations and codes of practice, and working with local authority partners by inspection, investigation and enforcement. gov.uk[1]
2. The Control of Major Accident Hazards Regulations 2015 ('COMAH') main aims are to prevent and mitigate the effects of major accidents involving dangerous substances which can cause serious damage/harm to people and/or the environment. COMAH mainly affects the chemical industry, but also some storage activities, explosives sites, nuclear sites and other industries, where threshold (and above) quantities of dangerous substances identified in the regulations are kept or used.

3. COMAH Regulation 5(1) Every employer must take all measures necessary to prevent major accidents and limit their consequences to human health and the environment.
4. More about the legislation referred to in this case can be found at: legislation.gov.uk[2]
5. HSE news releases are available at http://press.hse.gov.uk

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Food processing company fined after worker suffered thumb amputation

Troy Foods Ltd has been sentenced for safety breaches after a production supervisor suffered a serious injury when his hand came into contact with dangerous parts of a potato processing machine.

Leeds Magistrates' Court heard that, on 2 September 2019 at the site at Royds Farm Industrial Estate, Farm Road Leeds, the supervisor was cleaning out machinery between product runs when his hand came into contact with a rotating auger which was not adequately guarded. He sustained injuries which resulted in a thumb amputation and a broken finger.

An investigation by the Health and Safety Executive (HSE) found that access to the dangerous rotating auger was possible because the bagging unit conveyor and auger were not adequately guarded, and the machine did not comply with safety reach distances set out in BS EN 13857.

Troy Foods Ltd of Unit 1 Intermezzo Drive Leeds West Yorkshire pleaded guilty to breaching Regulation 11 (1) of the Provision and Use of work Equipment Regulations 1998. The company has been fined £33,333 and ordered to pay £670.53 in costs and a victim surcharge of £180.

After the hearing, HSE inspector Julian Franklin commented: "Employers should make sure they properly assess and apply effective control measures to minimise the risk from dangerous parts of machinery.

"This incident could so easily have been avoided by simply carrying out correct control measures and safe working practices"

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2. More about the legislation referred to in this case can be found at:

legislation.gov.uk/ [2]

3. HSE news releases are available at http://press.hse.gov.uk[3]
4. Please see the link below to the page on HSE's website that is the best guide to doing it the right way https://www.hse.gov.uk/work-equipment-machinery/puwer.htm

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Diving instructor sentenced after trainee dies during dive

A technical diving instructor has been sentenced after he failed to properly assess the competency of two pupils prior to a deep-water dive in Scotland, which ended in a fatality.

Edinburgh Sheriff Court heard how on 8 July 2017, William Peace and another pupil were due to take part in a 45m dive off the coast of Dunbar to the wreck of the U74E – a 755-tonne German mine laying submarine, which sank in 1916. The men were taking part in closed-circuit rebreather diving, which is more technical than scuba diving and enables divers to dive to greater depths. They had joined technical diving instructor Ashley Roberts, sole director of Ash Roberts Technical Limited, to complete their Technical Diving International (TDI) mixed gas closed-circuit rebreather course. They were also accompanied by a friend of Mr Roberts.

As the students had not completed all of the online course pre-requisites, Mr Roberts determined that the planned dive would be a free diving session and fun dive rather than a training dive where he would check the students abilities in-water and provide feedback to them prior to enrolling them on the course and starting the training the following day.

Mr Roberts determined that they would complete an assessment dive to a maximum depth of 45 metres to assess their competency. After entering the water, they descended a shotline slowly to 13 metres, when Mr Roberts' friend disappeared from view. Mr Roberts travelled back up the line to the surface to check on his friend to find he had abandoned the dive as his dry suit was leaking water.

When Mr Roberts returned down the line to a depth of 13 metres, the two students were out of sight, having continued to the seabed. Mr Roberts travelled down the line, but couldn't locate them.

Once they had reached the seabed, they encountered difficulties and Mr Peace became unresponsive.

His dive buddy made several attempts to rescue Mr Peace, but was forced to return to the surface for his own safety. Mr Peace's body was later recovered by police divers using a sonar search.

An investigation by the Health and Safety Executive (HSE) found that Ashley Roberts did not conduct a suitable assessment of the competence of the pupils prior to commencement of the dive. Although an assessment dive was carried out it was not sufficient to measure the capability of the divers and should have been carried out at a depth much shallower than 45m. There was also a failure to verify the number of rebreather hours Mr Peace had completed during his previous dives or to check each diver's rescue ability. The men should have been under the supervision of an instructor at all times and particularly during an assessment.

Ashley Roberts, of Huddersfield, West Yorkshire, pleaded guilty to breaching Section 3(1) and Section 37(1) of the Health & Safety at Work etc Act 1974. He was fined £2,300.

Ash Roberts Technical Limited was dissolved on 9 July 2019.

Speaking after the hearing, HSE specialist diving inspector Alister Wallbank said: "This was a highly traumatic incident for all involved and a tragedy for William Peace and his family. Mr Roberts was responsible for the appropriate level of assessment, instruction and supervision. The conduct of Mr Roberts undertaking at the pre-dive and assessment stages exposed William Peace and his co-pupil to increased risks to their health and safety than might otherwise have been the case.

"Diving is inherently risky and particularly more so when divers are undergoing training and assessment. There are many potential risks and it is ultimately the responsibility of the diving instructor to manage these risks when supervising, training or assessing in what are often dynamic situations."

He added: "Many diver training courses require an initial assessment dive in order to establish that divers can demonstrate the required pre-requisite competency before progressing to formal training and assessment of more advanced skills and techniques. Competency is a combination of skills, knowledge and experience, it is a recognised fact that many previously learned diver skills can fade over time if not routinely or recently practiced. It is vitally important that a diving instructor adheres to the training guidance provided by the diving federation under which they are instructing and conduct these initial assessment dives in such a way as to reduce any risks so far as is reasonably practicable."

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2. More about the legislation referred to in this case can be found at: legislation.gov.uk/

3. HSE news releases are available at http://press.hse.gov.uk
4. Guidance and practical advice on complying with the Diving at Work Regulations 1997 for recreational diving instructors who are at work is contained in the Recreational diving projects: Diving at Work Regulations 1997 Approved Code of Practice