Offshore oil company fined for hydrocarbon release

Offshore oil company Apache has been sentenced after they failed to provide written safety procedures for the depressurisation of an oil well, which led to the release of more than 1000kg of hydrocarbon gas at their Beryl Alpha production installation in the North Sea.

Aberdeen Sheriff Court heard how, on 2 June 2014, Apache had allocated a production technician to carry out a depressurisation task on one of their oil wells, which he had performed on previous occasions. However, they failed to provide him with any written safety procedures, expecting him to carry out this complex task from memory.

The Beryl Alpha rig has 40 well slots and some of its oil wells are gas-lifted to increase production efficiency. The use of gas lift means that there are large inventories of pressurised hydrocarbon gas, any uncontrolled release of these inventories is a potential major hazard event.

At approximately 19.40, four flammable gas detectors had detected gas in the area and automatically activated the platform water deluge system. The general platform alarm sounded, and all 134 workers went to their muster stations. The gas release continued, and the installation remained at muster station for more than six hours.

An investigation by HSE found that deficiencies in Apache's safety management system (SMS) lead to a release of more than 1000kg of hydrocarbon gas. They had failed to carry out a risk assessment for depressurising gas lift wells, which meant there was a lack of suitable written procedures. The use of a formalised written procedure by Apache would have ensured that this task was carried out correctly in a safe and consistent manner across all staff shifts, preventing the safety critical emergency shutdown system from being disabled during well depressurisation. The prolonged duration and magnitude of the release was a direct consequence of the inadvertent defeating of the emergency shutdown system in this instance.

Apache Beryl Limited of Caledonia House, Prime Four Business Park, Kingswells Causeway, Aberdeen pleaded guilty to breaching regulation nine of the Offshore Installations Prevention of Fire and Explosion, and Emergency Response Regulations 1995 (PFEER). They were fined £400,000.

Speaking after the hearing HSE principal inspector Dave Walker said: "Although the offshore industry has managed to reduce its overall number of hydrocarbon releases, it is still the case that in most years there are several, which are of such a size that if ignited would result in potentially catastrophic consequences.

"At more than 1000kg, Apache's Beryl Alpha's hydrocarbon release was the largest reported to HSE in 2014. It occurred during complex work on a well,

which used a large volume of high-pressure gas to improve production rates, the hazardous nature of which had been highlighted in specific HSE guidance.

“The depressurisation of an oil well is a safety critical task, and so should have been formalised in a written procedure to set out a specified sequence of operations to perform the task correctly and prevent potential fatal consequences.”

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

The post Offshore oil company fined for hydrocarbon release appeared first on HSE Media Centre.

NHS Trust fined following failures to manage environmental risks

Essex Partnership University NHS Foundation Trust (EPUFT) has been fined for failing to manage environmental risks within its mental health inpatient wards. These breaches were committed by North Essex Partnership University NHS Foundation Trust (NEPUFT) before EPUFT came into existence.

Chelmsford Crown Court heard that, between 25 October 2004 and 31 March 2015, NEPUFT failed to effectively manage recognised risks from potential fixed ligature points in its inpatient wards, resulting in mental health patients being exposed to unacceptable and avoidable risk at a time when they were most vulnerable. Tragically eleven inpatients died during this timeframe whose deaths involved access to fixed ligature points.

An investigation by the Health and Safety Executive (HSE) found that NEPUFT failed to adequately identify, or address with sufficient urgency, the significance of the environmental risks within its inpatient wards.

Essex Partnership University NHS Foundation Trust of The Lodge, Lodge Approach, Runwell Wickford, Essex pleaded guilty to breaching Section 3(1) Health and Safety at Work Act 1974. The Trust was fined £1,500,000 and ordered to pay costs of £86222.23.

“I hope this case acts as a reminder to all mental health trusts of the need to continue to review their current arrangements and ensure their service users receive the protection they need at, what is often, their most vulnerable time.”

Det Chief Insp Stephen Jennings, the Senior Investigating Officer who led the Essex Police investigation into the North Essex Partnership University Foundation Trust (NEPUFT) welcomed today’s sentencing. He said: “I hope the conclusion of this HSE prosecution against NEPUFT, which we have supported throughout, now gives the families time to continue to grieve in peace.

“Following a full investigation, which began in 2017, into the circumstances of a number of deaths, and following expert legal advice, the evidential threshold was not met to allow us to take the Essex Police investigation any further. However, we ensured all of the evidence we had gathered was given to our HSE colleagues to support their investigation and it has unquestionably helped to secure this result.”

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2. More about the legislation referred to in this case can be found at: www.legislation.gov.uk/
3. HSE news releases are available at http://press.hse.gov.uk
4. Until the 1 April 2015, decisions whether or not to investigate patient safety matters in England were made in line with our HSWA Section 3 policy: http://www.hse.gov.uk/enforce/hswact/priorities.htm. After this date, the Care Quality Commission (CQC) became the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.

5. HSE has not investigated individual patient deaths. Where a patient death appears to have been possible due to access to a ligature point, HSE reviewed the suitability of the arrangements that were in place at that time to manage this risk in relation to relevant health and safety legislation.
6. The investigation timescales predate the existence of Essex Partnership University NHS Foundation Trust which came into existence when North Essex Partnership University NHS Foundation Trust (NEPUFT) merged with another trust.

The post NHS Trust fined following failures to manage environmental risks appeared first on HSE Media Centre.

Gas installer prosecuted for illegal gas work

A gas installer has been fined after carrying out gas work whilst falsely claiming to be gas safe registered.

Manchester Magistrates' Court heard how, between 1 October 2018 and the 25 November 2018, Mr Paul Chappells carried out gas work at two domestic properties in Hyde and Poynton but did not hold the necessary registration to complete this work. Mr Chappells replaced a gas fire and capped off the supply at the property in Poynton and replaced a boiler at the property in Hyde. The work on the boiler was later found to be of a poor standard and was identified as "at risk" by a Gas Safe Inspector.

An investigation by the Health and Safety Executive (HSE) found that Mr Chappells was not registered with Gas Safe at the time the work was undertaken at both properties, despite advertising as gas safe registered on his social media account resulting in him illegally carrying out the gas work.

Mr Paul Chappells of Withington, Manchester, pleaded guilty to breaching regulation 3(7), 26(1) and two counts of regulation 3(3) of the Gas Safety (Installation and Use) Regulations 1998. He was sentenced to a community order of 250 hours unpaid work of eighteen months duration, fifteen rehabilitation activity days and ordered to pay costs of £1,000.

HSE inspector Lorna Sherlock said after the hearing: "Paul Chappells undertook gas work which he knew he was not registered to do. Householders should check that the engineer carrying out gas work in their home is registered with Gas Safe.

“All gas work must be done by registered Gas Safe engineers to ensure the highest standards are met to prevent injury and loss of life.”

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2. More about the legislation referred to in this case can be found at: legislation.gov.uk/
3. More information about domestic gas health and safety can be found at https://www.hse.gov.uk/toolbox/gas/htm
4. HSE news releases are available at http://press.hse.gov.uk

The post Gas installer prosecuted for illegal gas work appeared first on HSE Media Centre.

Construction company fined after employee sustains life changing injuries in roof fall

A construction company based in Chesterfield has been fined after a subcontractor hired to complete work on a roof fell from the roof joists to the concrete floor below sustaining life changing injuries.

Nottingham Magistrates’ Court heard that, on 19 June 2019, Bobby Oldham Construction Limited (BOCL) were contracted to complete work on a domestic extension at Mona Road, West Bridgford, Nottingham. The work was to complete an extension to the rear of the property, which contained a skylight and wooden joists. Work had progressed to the point where roof joists were being attached. The joists were accessed using a ladder, which then led to an unprotected trestle platform. The subcontractor was sat astride one of the joists when it gave way causing him to fall. He landed on the concrete floor below sustaining serious injuries including brain trauma and a broken neck.

An investigation by the Health and Safety Executive (HSE) found that had the company properly considered the risks associated with this type of work, and planned the work at height more carefully the incident could have been easily avoided. The trestle platforms were missing suitable edge protection, and there was an absence of other suitable fall mitigation measures such as airbags. The work was not supervised, which would have identified the unsafe working methods, which could then be challenged by the company.

Bobby Oldham Construction Limited (BOCL) of Market Street, Staveley, Chesterfield, Derbyshire pleaded guilty of breaching Regulation 4(1) of the Work at Height Regulations 2005. They were fined £8,000 and ordered to pay costs of £3,515.

Speaking after the hearing HSE inspector Phill Gratton said: “This was a tragic and wholly avoidable incident, caused by the failure of the host company to implement safe systems of work, and failure to ensure that work at height was properly planned and appropriately supervised.

“This risk was further amplified by the company’s failure to undertake a number of simple safety measures including conducting pre-start checks on the training of workers, planning work to ensure that working methods were safe, and supervision to ensure that dangerous working methods could be observed and challenged.“

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The post Construction company fined after employee sustains life changing injuries in roof fall appeared first on HSE Media Centre.

Two care provider companies fined and a manager cautioned after employee stabbed

A Liverpool care agency, that supports people with mental health issues, its manager and a care home have been fined after an employee was stabbed by one of its residents.

Liverpool Crown Court heard that on the 2 November 2014 an employee of Options for Supported Living was undertaking a regular scheduled visit to assist the transition of services for a resident from Fulwood Care Ltd at Ampthill Road, Aigburth to Options for Supported Living. During the visit, the untrained Options employee was left alone in the kitchen with the individual despite the care plan stating that the resident, whose violence and aggression had been clearly identified, required the attendance of two care workers at all times. Whilst the employee was unaccompanied, the resident crossed the kitchen and stabbed the employee in the right side of her neck.

While the employee made a physical recovery, she has suffered post-traumatic stress disorder (PTSD) and long-term psychological trauma and is still receiving counselling.

An investigation by the Health and Safety Executive (HSE) found that despite care plans and risk assessments being in place from the City Council, the NHS Mental Health Trust and Fulwood Care Limited, all of which indicated the high risk the individual posed to themselves and others, neither Fulwood Care Limited or Options for Supported Living took account of these documents prior to the visits by Options for Supported Living. This included the manager at Supported Living, Marie Binns.

It was also found that dedicated training and a full risk assessment and care plan for that individual were not undertaken by Options for Supported Living in order to identify the triggers for violence and aggression, and how the risk could be managed. The need for 2:1 supervision, triggers (things not to say or do) should have been identified and copies of the documents given to Options employees prior to their visits. Arrangements with regard to communication and supervision by the two care agencies should also have been

undertaken and adequate supervision during visits provided by both Options and Fulwood Care.

Options for Supported Living Ltd of St Nicholas House, Old Church Yard, Liverpool, pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974 and was fined £31,000 and ordered to pay £10,000 towards costs.

Fulwood Care Ltd of Ampthill Road, Aigburth, Liverpool pleaded guilty to breaching Section 3 (1) of the Health and Safety at Work etc. Act 1974 and was fined £14,000 and ordered to pay £10,000 towards costs.

Marie Binns of Queens Drive, West Derby, Liverpool accepted a formal caution with regard to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974.

HSE inspector, Rose Leese-Weller, said after the hearing: “This was a tragic and wholly avoidable incident. Those in control of work have a responsibility to devise safe methods of working and to provide the necessary information, instruction and training to their workers.

“If a suitable safe system of work had been in place prior to the incident, the individual in care may not have reacted the way they did, and life changing injuries sustained and trauma experienced by the Options employee could have been prevented.”

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2. More about the legislation referred to in this case can be found at: INDG69.R8 Violence at Work: A guide for employers.
3. HSE news releases are available at http://press.hse.gov.uk