Housing association fined after exposing employees to Hand Arm Vibration Syndrome (HAVS)

A community housing association has today been sentenced after it failed to effectively manage its employees' exposure to Hand Arm Vibration Syndrome (HAVS) over a prolonged period of time.

Newport Magistrates' Court heard how, between July 2010 and May 2015, employees of Tai Calon Community Housing Limited were routinely exposed to vibration in their day to day work. Following the company's introduction of health surveillance in May 2015, a number of employees were diagnosed with HAVS which has side effects such as pain and loss of strength in the hands and has been known to cause distress and sleep disturbance.

An investigation by the Health and Safety Executive (HSE) found Tai Calon failed to adequately assess the risk to employees from the use of vibratory tools, failed to implement adequate measures to reduce employees' exposure to vibration, failed to place employees under suitable health surveillance and failed to provide employees with suitable information, instruction, and training.

Tai Calon Community Housing of The Rising Sun Industrial Estate, Blaina, was found guilty of breaching Section 2(1) of the Health and Safety at Work, etc Act 1974 and was fined £30,000and ordered to pay £2789.25 in costs.

Speaking after the hearing, HSE inspector Paul Newton commented: "No one's health should not be made worse by the work they do. In this case, if Tai Calon had understood why health surveillance was necessary, it would have ensured that it had the right systems in place to monitor its workers' health.

"This prosecution highlights the health risks from using vibratory tools and the importance of employers having a health surveillance programme in place. Where vibratory tools are used, employers should monitor the health of employees using them and ensure appropriate systems are in place to manage and control the risk from vibration."

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: legislation.gov.uk/

3. HSE news releases are available at http://press.hse.gov.uk

Journalists should approach HSE press office with any queries on regional press releases.

Agency worker crushed while unloading a vehicle

A logistics company has today been fined after a worker suffered crush injuries while unloading a vehicle from a visiting delivery lorry.

Southend Magistrates' Court heard how, on 14 December 2015, an agency worker was unchaining a vehicle ramp from a delivery lorry when the lorry moved forward with one chain still attached to the ramp, crushing the worker between the ramp and a barrier.

An investigation by the Health and Safety Executive (HSE) into the incident found the company failed to fully control the risks arising from the operation of vehicle loading and unloading ramps. The company did not implement suitably robust systems of work; did not provide sufficient training to allow workers to safely unload vehicles; and did not appropriately brief visiting drivers on their role in this activity.

ERIKS Industrial Services Limited of Amber Way, Halesowen, pleaded guilty to breaching Section 3(1) of the Health and Safety at Work Act 1974 and has been fined £373,000 and ordered to pay costs of £8,333.

Speaking after the case, HSE inspector Tim Underwood said "This incident could have been avoided if the company had created a more detailed risk assessment and introduced a fully considered safe system of work. Removing the visiting lorry driver's keys until the procedure was safely completed, is one such method which could have prevented such an occurrence.

"Companies have a responsibility to provide sufficient information, instruction and training to all those involved in workplace transport operations (including visiting delivery drivers), in order to control the risk of serious personal injury."

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Egg Producer and Joinery Contractor fined after worker falls from roof

A Preston egg production company and a joinery sub-contractor were today fined after a worker fell through a roof.

Preston Magistrates' Court heard how an employee of T& J Leigh had been helping the joinery contractor Harry Jackson to re-roof an old feed mill building when he fell five metres through a gap, to the concrete floor below causing serious head and arm injuries.

The HSE investigation into the incident, which took place at Ghyll View Farm in Longton on 1 November 2016 found the roof work was not properly planned with no measures in place to prevent or mitigate a fall through or from the roof.

T & J Leigh (a partnership) of Ghyll View Farm pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc act 1974 and has been fined a total of £50000 with costs of £2855.32.

Harry Jackson of Much Hoole pleaded guilty to breaching Section 3 (2) of the Health and Safety at Work etc act 1974 and was given a 16 week prison sentence, suspended for 12 months. He was also ordered to carry out 150 hours unpaid work and pay costs of £2855.32.

Speaking after the hearing, HSE inspector Steven Boyd said: "This avoidable incident resulted in serious injuries, a fall from this distance could easily have been fatal.

"Roof work should always be properly planned with measures put in place to prevent a dangerous fall.

"Companies commissioning roof work should make reasonable checks regarding the competence of a contractor to undertake work at height safely"

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Essex engineer sentenced for unregistered gas work

A worker has been sentenced after breaching a prohibition notice for gas work and for leaving gas appliances in a dangerous state.

Chelmsford Magistrates' Court heard that in July 2015 Gary Miller disconnected and removed a boiler from a domestic property in Brentwood, and installed a replacement with associated pipework.

An investigation by the Health and Safety Executive (HSE) found that Mr Miller had previously been issued with a prohibition notice for undertaking unregistered gas work in 2013, and had not since gained a registration. The gas work carried out by Mr Miller was inspected by a Gas Safe inspector who found it to be "at risk" meaning that the appliance, if operated, may have been a potential danger to life or property. Mr Miller had intended for a registered engineer to sign off the work, once he had installed the gas appliance, which is also not permissible under the regulations.

Gary Miller, of Fairfield Road, Ongar, pleaded guilty to breaching Regulation 3(3) of the Gas Safety (Installation and Use) Regulations 1998, and Section 22 of the Health and Safety at Work Act 1974. He has been sentenced to a 12-month Community Order with 100 hours of unpaid work.

Speaking after the hearing, HSE inspector Adam Hills said: "Gary Miller undertook gas work when he knew he was not registered to do so. HSE will not hesitate to take appropriate action against rogue gas fitters who disregard the law and place lives at risk. Working with gas appliances is difficult, specialised and potentially very dangerous, so it is vital that this is only undertaken by trained and competent engineers who are registered with Gas Safe."

Jonathan Samuel, chief executive of Gas Safe Register, added: “Every Gas Safe registered engineer carries a Gas Safe ID card, which shows who they are and the type of gas appliances they are qualified to work on. We always encourage the public to ask for and check the card, and if they have any concerns about the safety of work carried out in their home, to speak to us.”

For more information about gas safety visit
http://www.hse.gov.uk/gas/index.htm

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Southern Health NHS Foundation Trust fined after deaths of two patients

Southern Health NHS Foundation Trust has been fined £2m after a series of management failings led to the deaths of two vulnerable patients at different facilities owned by the Trust.

The Health and Safety Executive (HSE) prosecution follows the deaths of 45-year-old Teresa Colvin at a Southampton Mental Health Hospital and the death of 18-year-old Connor Sparrowhawk at a specialist unit in Oxford. Both centres were under the management of Southern Health NHS Foundation Trust.

Oxford Crown Court heard both HSE investigations found a series of management failings leading up to both deaths including a failure to control risks, and failures in planning.

Southern Health NHS Foundation Trust, pleaded guilty to two breaches of Section 3(1) of the Health and Safety at Work etc. Act 1974. For the breach relating to Teresa Colvin, the sentence was a £950,000 fine. For the breach relating to Connor Sparrowhawk’s death, the sentence was a fine of £1,050.000.

HSE’s deputy director of field operations Tim Galloway said: “These tragic incidents could have wholly been avoided with better supervision and planning. Instead two families are left utterly devastated and let down by those who had a duty of care for their loved ones.

“The Trust was responsible for caring for those suffering with mental health issues and caring for those with learning difficulties. On these two occasions it failed these two patients and their families.

“Our thoughts remain with Connor Sparrowhawk and Teresa Colvin’s families as they continue to come to terms with these avoidable tragedies.

“In particular, we would like to pay tribute to Dr Sara Ryan, Connor’s mother, for her continued campaigning on these tragic issues.”

BACKGROUND OF CASE

Death of Connor Sparrowhawk

On 4 July 2013, 18-year-old Connor Sparrowhawk died after suffering an epileptic seizure in the bath at the Trust’s specialist unit, Slade House in Oxford.

An investigation by the Health and Safety Executive (HSE) found that despite Mr Sparrowhawk’s vulnerability and previous suspected seizures, he was allowed to use the bath alone with checks from staff taking place every 15 minutes.

Tim Galloway added: “Southern Health was aware of the patient’s condition and there had been a number of warning signs prior to the incident taking place. Allowing Connor to use the bath unsupervised was an obvious risk and a serious management failing.”

Death of Teresa Colvin

Following Connor’s death, NHS England published the independent Mazars report in December 2015 into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust

In response to the report, and following an assessment of all the deaths that occurred on Southern Health premises from April 2011, HSE concluded that one death met the criteria for a full HSE investigation.

On 26 April 2012, Teresa Colvin was found slumped and unconscious at a telephone kiosk at Woodhaven Adult Mental Health Hospital in Southampton. She died a short time later following treatment.

It became clear during HSE’s investigation that the Trust failed to act on the findings of assessments that it could better control the risks associated with the use of phones with cords. There had been a history of patients across the Trust, including those at Woodhaven, using phone cords as a ligature.

Tim Galloway added: “The known risk of patients across the Trust using phone cords as ligature was never sufficiently addressed. This ultimately led to the death of this vulnerable patient.”

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2. After 1 April 2015, the Care Quality Commission (CQC) took responsibility in England for patient and service user health and safety for providers registered with them. Prior to this date, HSE had enforcement responsibility, hence its investigation and subsequent prosecution on this occasion.
3. More about the legislation referred to in this case can be found at: www.legislation.gov.uk/
4. HSE news releases are available at http://press.hse.gov.uk

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