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

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.

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

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

Company fined after apprentice suffers fractured skull at commercial vehicle maintenance company

A Birmingham based motor vehicle company has been fined after an apprentice suffered head injuries whilst undertaking maintenance work on a commercial vehicle.

Birmingham Magistrates' Court heard how the Central England Municipals Limited (CEML) apprentice employee was working alongside an experienced mechanic replacing air suspension bags beneath a 39,000kg trailer. The air suspension bag was still under pressure and ejected sideways striking the injured person.

The employee suffered a fractured skull and was placed in an induced coma as a result of this incident.

An investigation by the Health and Safety Executive (HSE) into the incident, which occurred on 5 June 2017, found there was a failure to assess risk, a failure to implement a safe system of work and a failure to ensure that employees were appropriately trained and monitored to ensure the task could be carried out safely.

Central England Municipals Limited (trading as M6 Commercials) of Nechells, Birmingham pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974 and has been fined £20,000 and ordered to pay costs of £921.40.

Speaking after the case HSE inspector Christopher Maher said: "If a suitable safe system of work has been in place prior to the incident, the life changing injuries sustained by the employee could have been prevented."

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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/
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Company fined after multiple safety failings

Quainton Logistics & Storage Ltd has today been fined after both putting workers at risk and allowing conditions on site to fall well below the expected standard.

Liverpool Magistrates' Court heard how, on 4 May 2016, operatives were smashing asbestos roof sheets with crow bars to remove them from a derelict warehouse in Bootle, Merseyside. In addition to the risk of asbestos exposure, workers were at risk of falling into open service pits as no edge protection or fall restraint equipment was in place. Workers were not provided with PPE and there were no toilet or washing provisions on site.

On site, operating a Mobile Elevated Work Platform (MEWP) and fork lift truck, were three operatives all of whom were foreign nationals and only one spoke English. In another area of the building, a MEWP was parked next to the open pits, only around 1 metre from the edge. The MEWPS and fork lift truck were in very poor condition, covered in broken asbestos cement sheets.

An investigation carried out by the Health and Safety Executive found that Quainton Logistics & Storage Ltd failed to put measures in place to manage the work or to ensure the health and safety of operatives. The company also failed to implement safe systems of work or correct procedures for removing asbestos material.

Quainton Logistics and Storage Limited, of Turnall Road, Widnes, pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974 and Regulations 15(2) and 28(6) of the Construction (Design and Management) Regulations 2015. The company was fined £14,000 and ordered to pay costs of £ 6,870.44.

HSE inspector Jacqueline Western said after the hearing: "Companies should be aware that HSE will not hesitate to take appropriate enforcement action against those that fall below the required standards."

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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 safe working in construction can be found at the following links:

http://www.hse.gov.uk/construction/cdm/2015/contractors.htm

http://www.hse.gov.uk/pubns/cis62.pdf

http://www.hse.gov.uk/constuction/faq-welfare.htm

http://www.hse.gov.uk/construction/faq-height.htm#general

http://www.hse.gov.uk/asbestos/essentials/index.htm

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

Company fined after worker injured

A manufacturer of agricultural equipment has been fined after a worker suffered two broken legs when a stack of metal sheets fell onto his ankles.

High Wycombe Magistrates' Court heard how an employee of K Two Sales Ltd accessed the rear of a guillotine to measure some off-cuts. There were around 20 sheets of 4mm thickness stacked on top of each other. He tried to remove one of them causing the whole stack to fall on him.

An investigation by the Health and Safety Executive (HSE) into the incident, which occurred on 10 January 2017, found the steel sheets were being stored without adequate means to prevent them from falling.

K Two Sales Ltd of Station Road, Haddenham, Bucks pleaded guilty to breaching Section 2(1) of the Health & Safety at Work etc Act 1974 and has been fined £22,000 and ordered to pay full costs of £1,647.20.

Speaking after the case, HSE inspector Stephen Faulkner said: "This injury could have easily been prevented had the risk should have been identified.

“Companies should be aware that HSE will not hesitate to take appropriate enforcement action against those that fall below the required standards”.

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2. More about the legislation referred to in this case can be found at: legislation.gov.uk/ and www.hse.gov.uk/pUbns/priced/hsg246.pdf
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.