

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>

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/](https://www.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/power.htm>

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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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](#)

[An annual gas safety check can keep us all safe](#)

Sarah Newton blog

If we can take one positive from the incredibly challenging past 18 months or so, it must be the acts of kindness and neighbourliness that we have all witnessed, especially during the difficult months of lockdown.

From those who worked to keep essential services running to getting the weekly shop for our vulnerable neighbours or simply making time to chat, the sense of community, connectivity and collective care is one thing that most of us have wanted to preserve as we have emerged from those dark times.

During Gas Safety Week, from 13 to 19 September, I urge everyone to continue in that spirit by encouraging relatives, friends and neighbours to get a gas safety check. Those who shielded through the lockdown months, are clinically vulnerable or having to work at home, may feel particularly nervous of allowing strangers into their home. I would like to reassure everyone that Gas Safety registered engineers are mindful of people’s concerns and all comply with Covid guidance procedures and protocols including wearing appropriate PPE and observing social distancing.

As winter approaches, we are all looking to crank up the central heating ready for that first cold snap. While gas is a safe and efficient way to heat our homes and water, if not properly maintained, appliances can pose a potential risk to ourselves and our neighbours. It's important that we make sure our boilers, cookers, fires and all other gas appliances are checked on an annual basis.

In rented premises, landlords have a responsibility to their tenants to ensure that appliances in rental properties are regularly maintained by a registered engineer.

We can all be guilty of procrastination and justifying to ourselves why we haven't done the things we know that we should. How often do we put things off because we're too busy or the costs may seem prohibitive? Almost a third of us (32%) haven't had a gas safety check in the past year even though it should be done annually. If that rings a bell with you, then I urge you to tick that particular item off your list and book an appointment with a Gas Safe registered engineer now. Having your gas appliances serviced regularly not only give you peace of mind but can help save you money in the long term.

It might feel that we have been bombarded with safety messages over the past year, but this is one thing you can do just once a year to keep safe through the winter months and beyond. By law all gas engineers must be on the Gas Safe Register. Visit the Gas Safety Week website [\[link\]](#) to find one in your area and book a gas safety check for yourself, your family, friends and neighbours.



Sarah Newton

HSE Chair

Company fined after worker crushed at coal face

Mining company, Three D's Mining Ltd has been fined for safety breaches following a fall of ground on the NW9 coal face at Dan-y-Graig No 4 colliery located near the village of Crynant, South Wales.

Swansea Crown Court heard that, on 15 November 2017, two workers were preparing the roof for the erection of supports with the use of a pneumatic chisel when 0.6 tonne of stone fell from the roof and hit one of the workers on his back. He suffered significant crush injuries, large pelvic haematoma and a three spinal fractures.

An investigation by the Health and Safety Executive (HSE) found that the company had not carried out an assessment of the strength of the timber. The 24mm timber used to support the roof was not strong enough. The timber was not industry standard half rounds or split bars which are 65mm thick.

Three D's Mining Ltd Dan-y-Graig No 4 Colliery, Neath Road, Crynant, Neath were found guilty of breaching Section 2 (1) and Section 3 (1) of the Health & Safety at Work etc Act 1974. Also, Regulation 3 (1) of the Management of Health and Safety Regulations 1999.

The company has been fined £100,000 payable over four years. Costs were not awarded as the company is entering administration.

Speaking after the hearing, HSE Principal inspector Adrian Taylor said: "Small coal operators should follow industry guidance on the use of support material on small coal faces. Any changes should be fully assessed to check suitability.

"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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