# Global engineering company fined after employees exposed to chemical spill

The fabrication division of Nasmyth Technologies Limited has been fined after four employees were exposed to hazardous substances that caused significant ill health and time off work as a result.

Poole Magistrates' Court heard how, on the 9 October 2017, between 150 and 200 litres of a chemical preparation, that included hydrofluoric acid, spilled across a large area of the factory floor in Wimborne, Dorset. Four workers were involved in the clean-up that took several hours. They were provided with inadequate personal protective equipment (PPE) and respiratory protective equipment (RPE) to undertake a clear up, for which they had no training. Some of them suffered ill health following the incident, which included an asthma attack, a severe headache, nausea, sore eyes and throat. One of the workers, whose symptoms persisted, was referred by his doctor to a specialist for treatment.

An investigation by the Health and Safety Executive (HSE) found that there was significant non-compliance regarding management of substances hazardous to health. The company had failed to carry out a suitable and sufficient assessment and had not prepared for this emergency situation. One of the failings was that the RPE (face masks) provided did not have the correct type of filter for protecting against hydrofluoric acid gas. Additionally, the type of RPE provided to workers relied on a good seal against the face in order to protect workers and no face fit tests had been undertaken to ensure the masks fitted the workers' faces. Furthermore, workers were unshaven meaning their beards or stubble prevented an effective seal of the RPE to their faces.

Nasmyth Technologies Limited of Nasmyth House, Coventry Road, Exhall, Coventry pleaded guilty to breaching Section 2(1) of the Health & Safety at Work 1974 Act. They were fined £13,000 and ordered to pay costs of £9,551.

Speaking after the hearing, HSE inspector Berenice Ray said: "This incident could have so easily been avoided had the company firstly undertaken a suitable and sufficient risk assessment and then implemented the necessary controls, including emergency arrangements for dealing with a chemical spill and the provision of instruction and supervision to ensure safe working practices are followed.

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

### Notes to Editors:

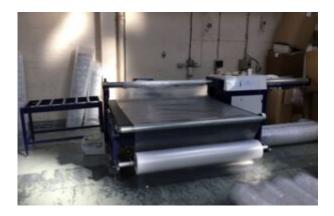
1. The Health and Safety Executive (HSE) is Britain's national regulator

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. <a href="https://example.com/health/healt

- 2. More about the legislation referred to in this case can be found at: legislation.gov.uk/
- 3. HSE news releases are available at <a href="http://press.hse.gov.uk">http://press.hse.gov.uk</a>
- 4. The Control of Substances Hazardous to Health Regulations 2002 (COSHH) is the law that requires employers to control substances that are hazardous to health. For more information on this, see <a href="https://www.hse.gov.uk/coshh/basics/index.htm">https://www.hse.gov.uk/coshh/basics/index.htm</a>

The post <u>Global engineering company fined after employees exposed to chemical spill</u> appeared first on <u>HSE Media Centre</u>.

## <u>Mattress manufacturer fined after</u> <u>employee dragged into machine</u>



A Nottingham mattress manufacturer has been fined after an employee of the company suffered multiple injuries to his arm, shoulder, ribs and neck after he was drawn into a NG-06 Semi-Automatic Mattress Rolling Machine (MRM).

Nottingham Magistrates Court heard how Dreamtouch Mattresses Ltd failed to prevent access to the dangerous parts of machinery on the MRM at the Chelsea Street site. As a result, the common practice at the site was for employees to use their hands, and or arms when feeding and pressing mattresses on the unguarded rotating winding film reel. Employees at the site confirmed there was no documented safe system of work or training for the use of the MRM.

An investigation by The Health & Safety Executive (HSE) found that the company did not prevent access to the dangerous parts of the machine and had not implemented a suitable and sufficient safe system of work which would

direct employees to not place their hands close to the dangerous parts of the machine.

Dreamtouch Mattresses Ltd, Chelsea House, Chelsea Street, Nottingham, NG7 7HP pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. They were fined £66,000 and ordered to pay costs of £4,836.20.

Speaking after the hearing, HSE Inspector Amandip Dhanda, said: "This injury was easily preventable, and the risk should have been identified. Employers should make sure they properly assess and apply effective control measures to minimise the risk from dangerous parts of machinery."

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- 4. Picture: The unguarded NG-06 Semi-Automatic Mattress Rolling Machine (MRM).

The post <u>Mattress manufacturer fined after employee dragged into machine</u> appeared first on <u>HSE Media Centre</u>.

## Foundry fined for exposing workers to hand-arm vibration risks

Saint-Gobain Construction Products UK Limited, a large foundry in Telford, has been fined after a number of its workers were diagnosed with hand arm vibration syndrome (HAVS).

Newcastle-under-Lyme Magistrates' Court heard how three employees, the earliest of which had used vibrating tools at the company since 1989, had developed and were subsequently diagnosed with HAVS in 2016. Despite the diagnosis, one of the workers continued working with vibrating tools, without effective measures to control the risk. The employees used tools such as hand grinders, air chisels, spindle grinders, and earlier on in their employment, jackhammers to finish cast iron drainage products.

An investigation by the Health and Safety Executive (HSE) found that until 19 December 2017, the vibration risk assessment did not identify each employee's

daily exposure to vibration and did not measure cumulative exposures of using different vibrating tools throughout a shift. The investigation also found there was inadequate health surveillance in place and employees were not made aware of HAVS and its symptoms. Despite health surveillance notifying the company of a HAVS diagnosis, the company had failed to take effective action to adjust the affected worker's job, meaning staff continued to be exposed to excessive vibration.

Saint-Gobain Construction Products UK Limited of Saint-Gobain House, East Leake, Loughborough, Leicestershire pleaded guilty to failing to discharge the duty imposed upon it by Section 2(1) of the Health and Safety at work etc Act 1974. They were fined £500,000 and ordered to pay costs of £9,453.

Speaking after the hearing, HSE inspector Andrew Johnson said: "This was an established multinational company that had the resources to protect its workers from the effects of excessive vibration, but failed to do so over a long period of time.

"All employers have a duty to provide effective measures to ensure the health of their staff is not seriously or permanently harmed by the work they are asked to do."

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The post <u>Foundry fined for exposing workers to hand-arm vibration risks</u> appeared first on <u>HSE Media Centre</u>.

## <u>Construction company sentenced after</u> <u>worker sustains life-changing injuries</u>

A construction company has been sentenced after a self-employed ground worker sustained life changing injuries in an incident involving a disc cutter.

Truro Crown Court heard how on 1 June 2017, self-employed ground worker Morgan Prosser, contracted by MJL Contractors Limited, was working to complete ground works at a new building site near Bodmin, Cornwall. Mr

Prosser was using a petrol disc cutter to cut reinforced concrete beams to size. Whilst he was doing this the saw 'kicked up' and caused a severe laceration to his arm. Mr Prosser underwent months of operations following the incident to try to save his arm. However, it had to be amputated In October 2017, which has had a significant impact on his ability to work and his personal life.

An investigation by the Health and Safety Executive (HSE) found that MJL Contractors Limited were responsible for the groundworks at the site, including providing and maintaining the disc cutter. Mr Prosser had not been sufficiently trained to use the petrol disc cutter and the system of work in use for cutting reinforced concrete beams had not been planned or assessed to ensure the risks were properly controlled.

MJL should have been aware that Mr Prosser had no previous experience of undertaking such a task and this should have been identified and addressed at his induction or at the time the work was allocated to him to complete.

MJL Contractors Limited of Hellys Court, Helston in Cornwall, were found guilty of breaching Section 3(1) of the Health & Safety at Work etc. Act 1974. They have been fined £250,000 and ordered to pay costs of £100,000.

Speaking after the hearing, HSE inspector Georgina Symons said: "The contractor's injuries have been life changing. This serious incident could have easily been avoided if basic safeguards had been put in place."

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The post <u>Construction company sentenced after worker sustains life-changing injuries</u> appeared first on <u>HSE Media Centre</u>.

## **Chemical manufacturing company fined**

## after employee scalded with boiling water

Calachem Limited, a chemical manufacturing company, has been fined after an employee was scalded with boiling water during a cleaning operation.

Falkirk Sheriff Court heard that on 4 March 2016, work was undertaken to clean down part of a production plant in Grangemouth, Scotland. The cleaning process involved filling a chemical powder charging chute leading down to a reaction vessel with water that was brought to the boil by immersing a steam hose in it.

The water in the chute was boiled overnight and the following day the employee continued with the clean down process. When he tried to empty the boiling water from the charge chute, he opened a valve expecting the water to drain down into the vessel below. However, the vessel below the chute had been pressurised with nitrogen gas and when the valve was opened the pressure in the vessel was released, the scalding water erupted back up and out of the chute severely scalding the employee.

An investigation by the Health and Safety Executive (HSE) found that a relatively safe cleaning process of washing down the charge chute with cold water into the vessel below had evolved and changed over time. The process had developed into the practice of overnight boiling of water in the charge chute, while simultaneously pressurising the reaction vessel below as part of a recirculating cleaning cycle. The incremental changes to the cleaning process were not subject to a review of the company's risk assessment and the danger of pressurising a vessel below a chute of boiling water was not recognised, consequently no control measures were put in place to remove this danger.

The practice of filling the powder charge chute with boiling water has ceased since the incident. The processes to clean down the plant have been risk assessed to introduce new safer worker procedures.

Calachem Limited of Peters Square, Manchester pleaded guilty to breaching Section 2 of the Health and Safety at Work etc Act 1974. They were fined £560,000.

Speaking after the hearing, HSE inspector Gerard McCulloch said: "Those in control of working processes have a responsibility to assess the associated risks. If changes are made, which increase the level of risk, those in control of the workplace have a duty to reduce the risk back down to as low a level as reasonably practicable.

"If the decision to boil water in the chute instead of hosing it down with a cold water had been the subject of a risk assessment, the danger from the pressurised vessel below would have been identified prior to the incident. This would have prevented the employee severe injury and permanent

disfigurement."

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