CORPORATE HEALTH AND SAFETY COMMITTEE - 16TH NOVEMBER 2015

SUBJECT: **RECENT HSE UPDATES**

REPORT BY: **INTERIM CHIEF EXECUTIVE**

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1. PURPOSE OF REPORT

1.1 The purpose of this report is to inform Members, Management and Trade Union Safety Representatives of recent updates in Health and Safety information, advice and guidance.

2. SUMMARY

2.1 The following report is provided as information for members of the Committee, to ensure they are kept informed of changes to health and safety legislation and approved codes of practice which will affect the Council, as well as advising of any relevant accidents, incidents and prosecutions.

3. LINKS TO STRATEGY

3.1 The report is provided as information to Members of the Health and Safety Committee in line with the Council's Health and Safety Policy.

4. THE REPORT

4.1 North Lincolnshire Council has been fined £160,000, and ordered to pay £40,476 in costs after pleading guilty to an offence under Section 3(1) of the Health and Safety at Work etc. Act 1974 after a man died when his car drove into a horizontal swing barrier gate to a car park at a sports ground.

Hull Crown Court heard how, in August 2012, the horizontal barrier had been opened earlier, but was not secured so it swung into a dangerous position. As the driver drove his car towards the gate, the horizontal end section of the barrier went through the windscreen striking the driver on the head, causing fatal injuries.

The barrier should have been secured whilst in the open position to a fixing post so that it could not swing into the access road and present an impalement risk.

A significant number of people have been killed or injured in incidents involving horizontal swing barriers in car parks used in retail, leisure and industrial premises.

Further information regarding the safety requirements of vehicle barriers access is available from the HSE website: www.hse.gov.uk/workplacetransport/barriers.htm

4.2 Aberdeen City Council and Aberdeenshire Council have been fined after pleading guilty to health and safety breaches following an incident in which an 11 year old child was found at the bottom of a local swimming pool during an educational excursion. During the visit he became submerged under water and was recovered unconscious from the bottom of the pool by a member of the public.

The court was told that the party of 23 pupils, the teacher and a teaching assistant arrived on the day of the excursion but no formal booking had been made. However, the pupils were allowed to swim in the pool which had water depth ranging from 0.8 metres in the shallow end to 2.2 metres at the deep end, with a water slide located at the deep end.

While the pupils were using the pool and slide, a member of the public using the pool noticed a shadow under the water at the deep end. On further investigation he found the child lying on the bottom of the pool. He recovered the unconscious child and lifted him onto the poolside. The alarm was raised and lifeguards were alerted. He was not breathing and had no palpable pulse, but CPR was successfully administered by lifeguards and the pupil has since made a full recovery.

The subsequent HSE investigation found issues with staffing levels and lifeguard positioning at the pool, and the effective management of educational excursions at the school. Both the local authority responsible for the school and the pool concerned pleaded guilty to breaching Section 3(1) of the Health and Safety at Work Act 1974. Aberdeen City Council was fined £9000 while Aberdeenshire Council was fined £4000.

4.3 North Yorkshire County Council has been prosecuted after a 14-year-old pupil needed a finger amputated after it got tangled in a lathe during a lesson at a comprehensive school.

The pupil was using a polishing cloth by hand on a work piece as it rotated on a manual metal lathe during a design and technology class when the incident happened. His right hand became entangled around the work piece and severed part of his index finger. There were six other mini lathes in use by pupils in the same class.

He was given first aid before being taken to hospital. After an unsuccessful operation to reattach the finger, the pupil needed to undergo further surgery to amputate the finger to below the first joint. He has needed several physiotherapy and occupational therapy sessions.

The HSE investigated and brought the prosecution after finding the Council had failed to identify that the practice of hand-polishing on metal lathes was unsafe despite it being used for years at the 1,700-pupil school.

Leeds Crown Court heard that after the incident, HSE served a prohibition notice on the Council, halting any use of hand-held polishing cloths on the lathes at King James' School and advising the authority to take action to ensure similar practices were not underway at other schools under its control.

HSE's investigation found that the Council's assessment of potential risks of using of the lathes had failed to consider all the tasks undertaken on the machine and so had not identified the unsafe system being used by pupils. As such, pupils were routinely put at risk of injury.

North Yorkshire County Council was fined £5,000 and ordered to pay £28,287 in costs after admitting a breach of the Health and Safety at Work etc. Act 1974.

Free guidance regarding the dangers of using emery cloth at metalworking lathes and safer alternatives can be viewed on the HSE's website: www.hse.gov.uk/pubns/eis2.pdf

4.4 Essex County Council has been fined £10,000 and ordered to pay £2,599 in costs, and a victim surcharge of £120 after a novice climber aged 15 plunged 7½ half metres from an indoor rock face at a climbing centre.

The 15 year-old girl was climbing on the indoor climbing wall whist being belayed by an eight year-old, who had only attended three previous climbing club sessions. On the day of the incident the eight year-old was using a certain belay device, for the first time. The climber lost her footing on the wall, but her younger belayer was unable to control her fall. She plummeted 7.5 metres onto the floor below. She suffered bruised internal organs, back and neck, as well as deep muscle tissue damage .

An investigation by the Health and Safety Executive (HSE) found the instructor was not competent to run this type of progressive climbing club session, as she did not have the required climbing training and site-specific assessment.

Chelmsford Magistrates' Court heard the instructor allowed the belaying to take place without use of an additional back-up belayer and without direct supervision from the instructor. There had been no use of a ground anchor or sand bag to counter the significant weight difference between the climber and belayer, and no application of safety knots to prevent the climber from falling to the ground.

4.5 Nottinghamshire County Council has pleaded guilty to breaching Regulation 3(1)(b) of the Management of Health and Safety at Work Regulations 1999 and been fined £6,000 with £5597 costs after an incident in which a three year old girl was struck by a park ranger's vehicle.

Nottinghamshire Council staff were using a lightweight all-terrain vehicle to travel around the Park whilst emptying litter bins at the Robin Hood Festival in August 2011. The utility vehicle on which two Council staff were travelling in went out of control and collided with a three-year-old child who was seated in a pushchair. The little girl suffered bruising to her head and leg.

The HSE told the court that its investigation had found the Council had not undertaken a suitable and sufficient risk assessment. HSE told the court that had it undertaken such an assessment then another method of collecting litter would have been used.

The court also heard the Council had received previous warnings in the shape of HSE Improvement Notices in relation to undertaking risk assessments.

4.6 Rochdale Metropolitan Borough Council has been fined £13,000 and order to pay full costs of £1,317 for safety failings after a two-year-old child had two fingertips severed when they were trapped in a gate at a playpark designed for children under 11 years old.

Trafford Magistrates' Court heard how the boy trapped his fingers in an external gate of the children's play area resulting in the injuries to his left hand.

The HSE told the court, because of the child's age, it was not possible to ascertain exactly what happened, but it seems he was playing by the gate when one of the other children shut it, causing the hinges to close, and creating a guillotine effect which severed his fingertips. The toddler had entered the park with his mother and three other children when the incident occurred.

The risk assessment in place at the time of the incident had only assessed the locking side of the gate and not the hinge side. The stopper mechanism on the gate had been removed and not replaced, some 12 to 18 months prior to the accident, and the hole it had left had been filled in by park staff. Despite several inspections of the play park by various different members of Rochdale Council staff, nobody noticed that the stopper had been removed, and so the risk remained.

4.7 Stafford Borough Council has been fined £20,000 and ordered to pay full costs of £1,922 and a victim surcharge of £120 after an incident at a theatre in which a worker suffered a fracture to the right side of sacrum (the bone at the base of the spine connected to the pelvis) and was unable to bear weight on his right leg for four weeks and couldn't return to work for more than two months.

Stafford Magistrates' Court heard two Stafford Gatehouse Theatre employees were using a tallescope (a telescopic aluminium manually operated work platform, used for one-person spot access) to undertake high level work to stage curtains and projector.

One of the workers was in the caged working platform at the top of the tallescope, approximately 4.5 metres high, as his colleague manoeuvred it around the stage to relocate it when the apparatus overturned.

The court heard a suitable risk assessment had not been carried out for the use of the tallescope at the theatre. If it had, the manufacturer's instructions on a warning label on the apparatus stating it should not be rolled with men or materials on platform should have been highlighted.

5. EQUALITIES IMPLICATIONS

5.1 There are no equalities implications.

6. FINANCIAL IMPLICATIONS

6.1 There are no financial implications.

7. PERSONNEL IMPLICATIONS

7.1 There are no personnel implications.

8. CONSULTATIONS

8.1 All comments from consultees have been included in the report.

9. RECOMMENDATIONS

9.1 That the contents of the report be noted.

10. REASONS FOR THE RECOMMENDATIONS

10.1 For information only.

11. STATUTORY POWER

11.1 Not applicable to this report.

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