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Health and Safety

CMS Newsletter

August 2014

Foreword

CMS Cameron McKenna LLP is recognised as a leading firm in the area of Health and Safety. We provide specialist advice on regulatory compliance, prosecutions, investigations and corporate governance.

Emergency Response Service

The steps a company takes immediately following an incident can be pivotal and can significantly increase or decrease the likelihood of a subsequent conviction. Health and Safety Inspectors have substantial powers to enter and examine premises, remove articles and demand documents necessary for them to carry out their investigations. Immediate, on the spot advice and support can therefore prove to be invaluable in the event of an emergency.

Our dedicated team is on call 24 hours a day to provide assistance and respond to incidents on site. Our lawyers are qualified to practice in England, Wales and Scotland; but we also regularly advise clients in relation to health and safety matters in other jurisdictions and can draw on the expertise of our CMS network of European offices.

We are available for health & safety emergencies and advice; along with any other related urgent matters. In the event of an emergency the team will ensure a swift and efficient response to client queries, irrespective of the time of day or day of the week.

If your company has a health and safety emergency, you can contact us on:

Emergency Response Hotline: 0333 20 21 010 (available 24 hours a day, 7 days a week)

London: 020 7367 3000

Edinburgh: 0131 228 8000

Aberdeen: 01224 622 002

Out of hours: 07811 362 201 (Ask for Jan Burgess)

Kelvin TOP-SET

A number of our team are qualified as approved Senior Investigators under the Kelvin TOP-SET incident investigation system. They are also able to assist in conducting an incident investigation itself, in order to ascertain the 'root cause' of an incident with a view to future preventative measures and improvements to health, safety and welfare.

Offshore Environmental Issues

Our team has considerable experience in advising in relation to offshore oil & gas issues – ranging from defending prosecutions by DECC to appealing enforcement notices – along with general advice in drafting of OPEPs and complying with the extensive range of offshore environmental regulation.

News

We reported previously on the Health and Safety Executive (HSE) consultations on the proposed replacement of the Construction (Design and Management) Regulations 2007, along with the revision of the Approved Code of Practice (ACOP) on the Provision and Use of Work Equipment Regulations 1998. Whilst these have since closed, the HSE recently opened several new consultations.

This newsletter looks at the exemption of certain self-employed persons from the Health and Safety at Work etc Act 1974, and the alignment of domestic and EU health and safety law. As recommended by the Löfstedt review, the HSE also continues to review ACOPs - this time with regard to the Dangerous Substances and Explosive Atmosphere Regulations 2002.

HSE open consultation on proposals to exempt self-employed persons from specific health and safety obligations

On 7 July 2014 the HSE began a period of consultation regarding their proposals to exempt self-employed persons from section 3(2) of the Health and Safety at Work etc Act 1974, except those undertaking activities on a prescribed list. The proposal to exempt certain persons originates from a recommendation made by Professor Löfstedt in his report, 'Reclaiming health and safety for all: an independent review of health and safety legislation'.

The HSE previously undertook a consultation focusing on the general policy of exempting some self-employed and the general principles of those exemptions. Having considered the results of the consultation, the HSE made recommendations for a clause to be drafted for inclusion in the draft Deregulation Bill. This clause would remove from the scope of section 3(2) of the HSWA those self-employed persons who pose no potential risk of harm to others.

The existing regulatory framework for health and safety, including section 3(2) of the 1974 Act, places general duties on everyone 'at work' and therefore encompasses the self-employed. Under section 3(2), a self-employed person is under a duty to "conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that he and other persons (not being his employees) who may be affected thereby are not thereby exposed to risks to their health and safety". The section is to be amended in order to exempt self-employed persons from the general duty in respect of themselves and non-employees, except for those undertaking activities on a prescribed list. "Prescribed" is defined by the HSWA to mean "prescribed by regulations made by the Secretary of State".

In the current consultation, the HSE is now seeking views on the clarity of the definitions of those self-employed persons who will continue to have duties under the health and safety law. The definitions have been set out in draft in the 'Health and Safety at Work etc Act 1974 (General duties of Self-Employed Persons) (Prescribed Undertakings) Regulations 2015'. These definitions delineate the activities during which self-employed persons will continue to have duties under section 3(2) of the 1974 Act. Where persons undertake activities falling beyond the scope of the definitions within the 2015 Regulations, they will be exempt from the section 3(2) obligations.

We have to question whether this rather complex system of 'exempting' and 'defining' is really going to make life simpler for the self-employed.

The consultation period closes on 31 August 2014.

HSE open consultation on the EU Classification, Labelling and Packaging Regulation

On 12 June the HSE opened a consultation on proposals to align domestic health and safety regulations with the EU direct acting Classification, Labelling and Packaging Regulation (CLP). The EU regulation, which comes fully into force on 1 June 2015, implements the United Nations Globally Harmonised System (GHS) on the classification and labelling of chemicals. Currently, many European directives reference the existing classification system to define their scope of application. When the CLP Regulation comes into force these references will become obsolete and will need to be replaced by relevant references to the CLP Regulation.

To reflect CLP, an amending directive has been adopted which updates five health and safety directives – including the Safety Signs at Work Directive. However, a range of domestic regulations also need to be amended in order to align them with CLP. These amendments will introduce CLP references, replacing any references to the existing classification system and hazard warning symbols with GHS and a new set of hazard pictograms. To make the necessary changes the HSE is proposing to introduce a set of amending regulations to come into force on 1 June 2015.

The consultation period closed on 5 August 2014.

HSE continues to review Approved Codes of Practice

On 11 June the HSE began a consultation to seek views on the proposed revised version of the Approved Code of Practice (ACOP) on the Dangerous Substances and Explosive Atmosphere Regulations 2002 (DSEAR) L133 – Unloading petrol from road tankers. The Regulations themselves remain unchanged and there are no new requirements for compliance.

The ACOP contains practical guidance on how to comply with the requirements of DSEAR in relation to the safe unloading of petrol at petrol filling stations. The HSE is required to consult on revisions to the ACOP prior to seeking Minister's consent to approve the revised edition.

Key changes proposed to the Code of Practice include:

- Increased emphasis on the importance of complying with the risk assessment elements of DSEAR.
- Expanded sections on overfill and spillage to provide further guidance in relation to these issues.
- Clearer definitions of some terms, for example maximum working capacity of storage tanks.
- Reorganisation of the text to ensure clarity on what is required to comply with the law for the various parties involved.
- Signposting to separate HSE guidance on working at height which enables the ACOP to focus on the key DSEAR elements of unloading of petrol.

The ACOP will remain separate from the second edition, L138, which incorporates the previous L134 – L137.

The consultation period closed on 22 July 2014.

Figures show 'all time low' for fatal injuries in the workplace

On 2 July 2014 the HSE released new figures which indicate that the number of British workers killed last year fell to the lowest amount on record.

Provisional data released by the HSE indicates that 133 workers were fatally injured between April 2013 and March 2014, compared with 150 over the same period in the previous year. This equates to a drop of 0.44 fatal injuries per 100,000 workers compared with 0.51 per 100,000 workers in 2012/13.

The 133 fatal injuries occurred in the following proportions:

- **England** – 106 fatal injuries, equivalent to a rate of 0.41 deaths per 100,000 workers, compared to an average of 134 deaths in the past five years and a decrease from the 119 deaths (and rate of 0.47) recorded in 2012/13;
- **Scotland** - 20 fatal injuries, equivalent to a rate of 0.78 deaths per 100,000 workers, compared to an average of 21 deaths in the past five years and a decrease from the 23 deaths (and rate of 0.90) recorded in 2012/13; and
- **Wales** – 7 fatal injuries, equivalent to a rate of 0.52 deaths per 100,000 workers, compared to an average of 10 deaths in the past five years and a decrease from the 8 deaths (and rate of 0.61) recorded in 2012/13.

The provisional figures also highlighted several industry sectors which are known to be particularly 'high risk' in respect of fatal injuries:

- **Construction** – 42 fatal injuries, equivalent to a rate of 1.98 deaths per 100, 000 workers, compared to a five-year average of 2.07.
- **Agriculture** – 27 fatal injuries, equivalent to a rate of 8.77 deaths per 100,000 workers, compared to the five-year average rate of 9.89.
- **Waste and recycling** – 4 fatal injuries, equivalent to a rate of 3.33 deaths per 100,000 workers compared to an average rate of 5.48 over a five-year period.

Judith Hackett, Chair of the Health and Safety Executive stated: "The release of the annual statistics always leads to mixed emotions. Sadness for the loss of 133 lives, and sympathy for their families, friends and workmates, but also a sense of encouragement that we continue to make progress in reducing the toll of suffering.

"Whilst these are only provisional figures, they confirm Britain's performance in health and safety as world class. For the last eight years we have consistently recorded one of the lowest rates of fatal injuries to workers among the leading industrial nations in Europe."

Cases

Firm fined after worker falls from roof

On 4 July 2014 a Potters-Bar based company was fined following an HSE investigation into an incident in May 2011. Reactive Roofing (UK) Ltd pleaded guilty to two breaches of the Work at Height Regulations 2005.

The Court heard how a 23-year-old worker from Dagenham was seriously injured when he fell four metres from the roof of a business park. The man suffered extensive injuries including fractures to his skull and wrist and major bruising to his back. He was hospitalised for five days.

The HSE investigation found that the company had failed to take adequate steps to properly plan the work or to ensure the provision of safety measures. In carrying out the work, workers relied on scaffold boards placed on top of fragile asbestos roof sheets in order to overlay the roof with wooden frames. During the installation of the final frame, the injured man had walked onto an unprotected section of the roof which gave way beneath him.

Stevenage Magistrates' Court found that the risks had not been fully assessed and the company ought to have ensured that suitable equipment, such as platforms, coverings or guard rails, was installed. Speaking after the hearing, HSE inspector Paul Hoskins said: "Simple measures such as using barriers to prevent access to fragile areas or safely installing adequate coverings over the fragile roof sheets would have meant workers were protected.

"It is essential that the hazards associated with working at height are recognised and understood by those carrying out the work. You should never work on a fragile roof without a safe system of work."

Reactive Roofing (UK) Ltd was fined £17,500 and ordered to pay costs of £7,077 following a guilty plea.

Further information about working safely at height can be found on the HSE website at http://www.hse.gov.uk/falls.

Council prosecuted following tree felling safety failings

On 3 July Newcastle Crown Court heard how Gateshead Metropolitan Borough Council and a tree surgeon were responsible for the felling of a tree onto a railway line, which subsequently injured a worker. The worker suffered a fractured right ankle, a cut to the back of his head and bruising on his left arm, left thigh and right forearm.

Mark Connelly, along with colleague Peter Wood, was contracted by the Council to fell two poplar trees in danger of falling on to the track. During the felling, one of the two trees became twisted and fell onto the track – uprooting another tree in the process. Both men failed to hear an approaching Newcastle to Carlisle Train whilst removing the tree from the track. The train was able to brake but hit the tree, causing injury to Mr Wood.

During court proceedings, Northern Rail stated that costs to repair the track amounted to more than £97,000. The rail operator incurred further costs including delay to services. Northern rail told the court that they had not been informed of the felling operation in the vicinity of the line. The HSE investigation concluded that the Council did not put in place safety measures that would have prevented the falling of the tree in the direction of the line. The HSE stated that Mr Connelly

had failed to properly plan the felling of the two trees, including a failure to adequately assess the risk of surrounding hazards such as railway lines.

The Council was fined £40,000 and ordered to pay £5,854 in costs after pleading guilty to breaching section 3(1) of the Health and Safety at Work etc Act 1974.

For more information about working safely in the forestry and arboriculture industries visit http://www.hse.gov.uk/treework/index.htm

Horse bedding manufacture firm fined after worker suffers crushed arm

On 3 July 2014 Equestrobed, a Suffolk based firm, pleaded guilty to a breach of section 2(1) of the Health and Safety at Work etc. Act 1974 after a worker's arm was crushed during the removal of compacted dust from a baling machine. The worker, 17 years old at the time of the incident, suffered serious injury to his arm including damage to his tendons, muscles and nerves which required two surgical procedures and a blood transfusion.

The man was working on the baling machine to clear debris which prevented the machine from working. During the removal of debris, the machine was activated - crushing the worker's arm in the process.

HSE's investigation revealed that the machine had not been adequately isolated from the power supply whilst debris was being removed. The HSE concluded that a suitable system of work had not been put into place to prevent access to dangerous moving parts of the machine.

The investigation highlighted the necessity for robust procedures to be put into place to manage interventions of heavy machinery. Bury St Edmunds Magistrates' Court imposed a fine on the company of £18,000.

Further information on the safe use of machinery can be found at http://www.hse.gov.uk/work-equipment-machinery/

Insufficient safety measures at construction site lead to serious injury for employee

On 3 July 2014 construction firm Galliford Try Infrastructure Ltd, trading as Morrison Construction, was fined £3,000 after Paul Fennelly suffered a serious leg injury during his employment. The sentence came after it was revealed that although certain safety measures were in place, the company had insufficiently considered the impact that an influx of water may have on the stability of its trenches.

Elgin Sheriff Court heard how, on 1 July 2011, a worker's leg had become trapped after the 1.3m deep excavation trench in which he was working collapsed. Mr Fennelly, a 45-year-old man from Hamilton, was working on the site near Duffus, Moray off the B9012. He was informed that the water supply had been turned off, and so began to cut a section of the cast iron water pipe. It was at this point a sudden torrent of water emerged from the pipe.

The employee instinctively moved to avoid the gush of water, causing part of the trench to collapse upon him. His right leg became trapped between the pipe and a significant weight of clay from the surrounding trench walls. Mr Fennelly suffered a fractured leg as a result of the incident and was hospitalised for ten days, requiring surgery. Following the procedure, he was made to use walking sticks for a further five months and was unable to return to work for eleven months.

The HSE promptly launched an investigation into the incident. It discovered that the company had correctly identified many of the risks involved in excavation work.

In order to address these dangers, daily inspections had been carried out on the trenches and training in excavation was provided. Crucially, however, less consideration was given to the potential issue of a sudden rush of water and the effect that this might have on the stability of the surrounding trench.

In failing to assess this aspect, the Edinburgh-based company was fined £3,000. Morrison Construction pleaded guilty to the breach of Regulation 31(1)(a) of the Construction (Design and Management) Regulations 2007.

HSE Principal Inspector Nial Miller commented that: "Risks relating to the collapse of excavations are long-standing and well-documented. As one cubic metre of soil typically weighs between 1.6 and 1.8 tonnes, even the collapse of a small quantity of material is potentially dangerous. Soil collapse can be rapid and completely without warning".

Miller stated that although the excavation had been dug appropriately, the company had not taken the problem of water into account. In failing to do so, the company had not assessed "whether additional protective measures were needed to prevent collapse, such as sloping or battering the sides or some form of support such as shoring".

The incident focuses the minds of employers on covering a wide range of possibilities and undertaking a thorough assessment of all risks involved in their work.

For more information about preventing danger to workers in and around excavations, please visit: http://www.hse.gov.uk/construction/safetytopics/excavations.htm

Recycling firm fined after contractors fall from height

On 3 July 2014 Eurokey Recycling Ltd, a Leicestershire-based recycling company, was fined £9,000 after admitting breaches of Regulations 4(1) and 5 of the Work at Height Regulations 2005. The order for payment came after two contractors fell from a height due to the safety failings of the company.

On 21 February 2013, 43-year-old Richard Norton and 30-year-old Craig Dunn were contracted to repair the roller-shutter door at the company's Hinckley facility. In order to carry out the work, they required access to the faulty component located between two and three metres from the ground. The contractors were informed that two forklift trucks were to be used in the repair. A caged container had been balanced on the prongs of each forklift, but these were not secured to the vehicles in any way. The workers entered the containers and were raised several metres high, where they carried out the task.

However, during the descent, the forklifts were lowered at different speeds. This destabilised the containers, causing them to fall two metres to the floor. Both men suffered injuries as a result. Mr Norton suffered a broken wrist and was absent from work for five months, whilst Mr Dunn tore several muscles in his back and could not work for twelve weeks.

An HSE investigation discovered that the containers did not have slots for the forklift prongs. The cages had not been strapped to the forklifts in any way. The men were unaware that the crates were not designed for human use, but were instead intended for the transport of goods. The recycling company was fined for its breach of the 2005 Regulations, with an additional order to pay £1,880 in prosecution costs.

HSE inspector David Lefever commented: "The system of work employed for the work activity was totally inappropriate and posed an obvious risk to the safety of the people being lifted. People should never be lifted on a pallet or similar container, balanced on the forks of a lift truck because they can easily fall off.

"Non-integrated working platforms, such as man-cages, may only be used in exceptional circumstances for occasional unplanned use. Examples might be maintenance tasks where it would be impracticable to hire-in purpose-built access equipment. That was not the case here." Advice on working at height can be found at www.hse.gov.uk/work-at-height/index.htm

Employee loses two fingers after string of safety failings

On 2 July 2014 a Dudley-based welding company was fined after failing to assess the risks posed to its employees by a hydraulic high-friction machine. MTI Welding Technologies Ltd was ordered to pay over £54,000 in fines and prosecution costs after an employee lost two fingers in an industrial accident.

On 23 August 2013 self-employed electrical contractor Ian Mowbray had been tending to a loading problem on a welding machine. The 49-year-old from Wolverhampton proceeded to press an incorrect button on the manual control panel. This action caused the powerful hydraulic holding fixture to close, trapping his left hand. Mr Mowbray's middle and ring fingers were so greatly crushed in the incident that they required amputation. He was unable to return to work for three weeks.

The company did not report the incident to the HSE. An inspection came about only as a result of an anonymous complaint four weeks later. The investigation went on to record repeated safety failings and disregard for safety procedure. It found that the machine in question had been acquired from another company, where it was modified from a formerly safe and automatically loaded fixture.

The altered machine was dramatically more dangerous than in its previous state. The safety interlocks had been overridden and manual controls had been introduced. This allowed workers to access the safety enclosure, which was in close proximity to moving parts, without stopping the machine. In addition, the manual buttons were located near the hydraulic fixture and operation could be initiated whilst employees remained in the danger zone. No precautionary measures had been taken to mitigate the increased risk as a result of the modification. No secondary guarding had been introduced and no emergency stop was available at the manual control.

Dudley Magistrates' Court sentenced the company to pay £53,000 in fines and £3,100 in costs. A plea of guilty had been submitted for breach of the Health and Safety at Work etc Act 1974, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, and the Provision and Use of Work Equipment Regulations 1998.

HSE inspector John Glynn stated that the company had conducted itself in a "grossly negligent" manner: "The company builds and sells its welding machines to major manufacturing companies worldwide. As original manufacturers they are fully aware of the legal requirements to supply machines with all the required safety measures.

"MTI Welding Technologies Ltd entirely failed to consider the risk to workers while engaged in manual operations. Had they done so a man would not have suffered a serious, painful injury."

The managing director of the company has since announced a full review of the systems in place and the implementation of changes to working practices throughout the organisation.

Logistics firm fined after worker falls from loading ramp

On 1 July 2014 Yusen Logistics, a firm based in Northampton, was fined following an HSE investigation after a man was seriously injured when he fell 1.5 metres from a loading ramp as he was unloading fridges at the firm's site in Kent. The agency worker suffered a leg fracture in the fall and was unable to return to work for three months.

The investigation found that the company had failed to fit out the ramp with additional edge protection guarding which the company's two other ramps had been fitted out with. The investigation determined that the loading ramp provided the worker with limited protection for unloading purposes. The HSE stated that falls from height remain a prevalent factor in fatalities and serious injuries caused to workers in the UK. The case also demonstrates that even a small height above ground level can result in serious injuries following a fall and can therefore lead to prosecution. The company admitted a breach of the Work at Height Regulations 2005. It was subsequently fined £11,000 and ordered to pay £1,067 in costs.

Contractor fined over pedestrian death resulting from failure to control vehicle movement

On 5 March 2014 Preston-based building contractor EMC Contracts Ltd was found guilty of offences under sections 2(1) and 3(1) of the Health and Safety at Work etc Act 1974. The company was ordered to pay £182,790 in fines and prosecution costs, having been held responsible for the death of employee Carl Green.

The company had been fitting a new coffee facility in a Lancashire cinema when the incident occurred. On 27 July 2010 an EMC employee finished unloading goods from his vehicle and began to reverse in a paved area outside the facility entrance. Unaware that his fellow employee was crossing behind the van, the driver struck Mr Green, who sustained fatal injuries.

The Health and Safety Executive launched an investigation and, immediately following the event, served a prohibition notice to cease work at the site until the hazards were addressed. During the investigation the HSE reported that although the company had correctly identified the danger that existed with regard to vehicles and pedestrians in close proximity, no steps had been taken to mitigate or eliminate that risk. The contractor had written a method statement in which it identified the potential hazard, but omitted the problem from the section discussing measures to be taken.

HSE investigating inspector Susan Ritchie commented that the seriousness of the incident was elevated due to the fact that the accident took place during the Summer holidays. This was a time in which the possibility of parents, children and youths being present was greatly increased. These individuals would have frequented the cinema more often and the risk of striking a pedestrian was therefore heightened.

A range of low cost measures were available which the company could have implemented to avoid the unfortunate incident. Their primary culpability was failing to separate pedestrians from vehicles whilst work was underway. Had the employer taken steps to prohibit the reversing of vehicles, or limit their presence at the cinema entrance, the fatality could have been avoided.

Preston Crown Court found EMC guilty of breaching both sections 2(1) and 3(1) of the HSWA 1974. On the first count, Judge Baker fined the company £100,000. He stated that the incident fell within the 2010 Sentencing Guidelines for offences that are a significant cause of death. The judge handed down a further fine of £30,000 for the second violation, with an additional sum of £52,790 to be paid in prosecution costs. Although the company was in voluntary liquidation, Judge Baker delivered the sentence on the basis that EMC would be able to pay the fines as the liquidator provided no information to the contrary.

Failure to control vehicle movement is an issue which health and safety practitioners are all too familiar with. In January this year, a Lincolnshire farming company was fined £200,000 when a farm manager was struck and killed by a forklift truck as a result of the farm's failure to segregate pedestrians and vehicles. According to a report by the HSE on Workplace Transport Safety, around a quarter of all deaths involving vehicles at work occur as a result of reversing. Pedestrians must be kept clear of vehicles and, if they have to interact, this is to be done in a controlled and measured manner. It is thought that the fines delivered in these cases will act as a deterrent and will reemphasise the need for companies to not only identify and acknowledge risks, but to seek to reduce or remove these hazards entirely.

We report regularly on the Corporate Manslaughter and Corporate Homicide Act 2007, which was heralded as a piece of landmark legislation on enactment. It introduced the offence of corporate manslaughter, meaning that companies and organisations can now be found guilty of corporate killing as a result of serious management failures resulting in a gross breach of a duty of care.

Although the Act came into force on 6 April 2008, the arising case law remains sparse. Nonetheless, the cases which have emerged are raising several key issues. The recent prosecution of MNS Mining Ltd is particularly interesting in both its content and implications going forward.

Focus On: The Corporate Manslaughter and Corporate Homicide Act 2007 and Associated Case Law

Corporate Manslaughter Update: MNS Mining Ltd

On 19 June 2014 MNS Mining was found not guilty of corporate manslaughter under the Corporate Manslaughter and Corporate Homicide Act 2007, following a three month trial at Swansea Crown Court. The mine manager, Malcolm Fyfield, employed by MNS was found not guilty of gross negligence manslaughter. The company was on trial for four offences of corporate manslaughter and the mine manager with four offences of manslaughter.

Background

The case arose as a result of a tragic accident on 15 September 2011 in which four workers drowned when the mine they were working in flooded. The mine was a small drift mine and in order to change the direction the mine was being worked in, there was a requirement for a ventilation and additional egress route to be created. On 14 September, the day before the incident, the mine manager instructed the men to break through a wall into old workings, by firing explosives, a method known as shot firing. It was the crown's case that on the other side of that wall there was already over 600,000 gallons of water, the equivalent to 1.5 Olympic sized swimming pools.

Crown case

It was the crown's case that the incident occurred as a result of the mine manager's "gross negligence" which arose when he instructed the mine workers to breach the wall within the mine. They further stated that the company was guilty of corporate manslaughter on the basis of the mine manager's alleged manslaughter. The case against the company focussed entirely on this premise; the company had duties which were breached as a result of senior management's failure, and it followed that the company was therefore guilty.

During the course of the trial, the crown led evidence from 45 witnesses speaking to fact, as well as experts. The defendants called just two witnesses – the mine manager gave evidence on his own behalf and a geological expert gave evidence on behalf of the company. During the crown-led evidence, 12 – 15 years of the mine's history was explored, and evidence was heard from mine surveyors, mine inspectors, HSE inspectors and water calculation experts.

In essence, the argument being made by the crown was that it was known how much water had been released in the incident into the mine where the workers were; that water came from an area above the break through point; that area was marked on the mine plans with a water line and the words "underground water"; those plans were available at the time of the incident; and post-incident calculations showed there was capacity for the water that came through in the incident to fit into that particular area of the mine. Moreover, the area surrounding the workings containing the "underground water" was marked on the mine plans by green hatching and this highlighted a cautionary zone. When mining into a cautionary zone, it was submitted that extreme care must be taken, as required by mining regulations, and that involved inspection and approval being sought from the inspectorate prior to work being carried out. It was the crown case that that wasn't done, and the mine manager was therefore grossly negligent.

In considering the level of negligence on the part of the mine manager, the crown argued that on the basis of the evidence, anyone could see that in carrying out the work that the mine manager instructed, there was a large quantity of water in the area designated on the plan, that it created

a massive risk to life and that was an unacceptable risk to take. Further, it was argued that mining regulations stipulate that the men must be 100m back from the area being shot fired. Although the men were in an area protected from the ordinary risks associated with shot firing, they were not in an area of safety to be protected from the massive inrush of water that eventuated.

Analysis of crown case

On the face of it, the crown's case was unanswerable. It appeared there was compelling evidence of the presence of water, there was a cautionary zone highlighted on mine plans, no approval had been sought from the inspectorate by the mine manager, as is required, and there was a rush of water causing death.

However the evidence produced on paper typically does not amount to the totality of the evidence that is to be given by witnesses. A case may look compelling; however it can ultimately be undermined by the reality, when it is brought out in cross examination.

As is required in criminal cases, statements are served during disclosure, which support the Crown's case. These statements are prepared based on the Police and HSE's questions and generally speaking, it is inevitable that they are going to be limited in content. Questions which may be relevant to the defence of the case may not be asked by the investigating officers. There may be more information available from that witness but it is simply the case that they have not been asked a particular question.

The defence challenge

By way of example, a former mine manager, with over 18 years of experience at the mine in question was called by the crown to give evidence during the trial. He gave evidence to the effect that in the course of his work in the mine, he knew that water would come into the mine and congregate in certain areas designated on the plan designated by the blue water lines. As such, he put in place a pipe, to carry the water away when it reached the blue line on the plan, removing any overflow. That meant that everything below the blue line on the map, symbolised water.

At interview, the mine plan was put to him. The former manager marked on the plan the start and finish points he took when carrying out inspections, in order to check ventilation. However prior to the Trial, he had never been asked what route he took in order to get from start to finish. He was first asked this question in cross examination, and so he drew the route he took. It transpired that the route took him half way through the area marked with the words "underground water" on the plan, the area which it was the crown's case, was the location of water. The witness advised that he did not know what the blue line (said by the crown to show the water line) was intended to represent.

The results of this line of cross examination seriously undermined the crown's case. If the former mine manager's evidence was to be accepted, it could no longer be stated as the crown alleged, that the entire area outlined on the map was full of water. Therefore, the amount of water the crown stated was present could not have fitted into the space. As such, it could no longer be said that the quantity of water released, was in place for a long time before the incident. This was a critical part of the crown's case.

The defence case

The defendant mine manager's position had always been that he carried out inspections three times before the incident, the final inspection being on the day before the incident, and there was no evidence of water. It was on that basis of those inspections that he had given the instruction to break through the wall. The defence case was therefore that the water must have arrived after the mine manager's inspection; at most, it had been there for 16 hours. However, the crown's case was that the mine manager was either lying, or he was seriously mistaken. They considered it to be too much of a coincidence that a massive body of water could congregate in that time.

Superficially, it did appear to be a massive coincidence. However, the evidence that had been heard from the former mine manager (if accepted) meant that the water which was released into the mine, could not all have fitted into the area designated on the plan with the words "underground water". As such, it must have been the case that there was a "coincidence" at some stage and at least some of the water, arrived just before the incident.

In support of its case, that the water that came through in the inrush was not present when the mine manager said he conducted his inspections but congregated in the hours following, the defence relied on the company's independent expert witness. The expert was a geologist who could speak to how the water could have gathered in the time frame the defence were suggesting, thereby bolstering the credibility of the mine manager's evidence, that he had carried out the inspections as he said. The defence argued that the mine manager's evidence should be believed, that he was not mistaken. The crown did not have an expert witness in a position to challenge the evidence of the geologist. They further relied only on a limited examination of areas of the mine where the water had gathered.

Further it was submitted for the defence that there was no direct evidence to rebut the mine manager; and there was direct evidence that previous managers had given evidence about mining into the areas supposedly marked as a cautionary zone and so it could not be said it was grossly negligent to mine into the area.

Jury direction

In light of the defence submissions and the evidence that had emerged, when it came to directing the jury, the judge said there was one question that must be addressed first, before looking at the case any further. If the prosecution had not convinced the jury that the mining manager did not carry out those inspections in the area he described, then they could not be sure that a large volume of water accumulated in the area behind the breach point for a significant period of time before the incident. If that was the case, then both the company and the individual could not be found guilty of the eight charges laid before them, and there would be no need to consider the case any further. The other questions for the jury would only have to be answered if they answered this first question in the crown's favour.

It would appear that the jury answered that question in favour of the defence. In week 13 at Swansea Crown Court, the jury left the court room at approximately 12.45pm to consider the case. Taking just 15 minutes to deliberate, followed by a break for lunch, they returned at 2.35pm to deliver not guilty verdicts in respect of all eight charges.

Advice

This case highlights that the importance of the witness stand must not be under-estimated. It is particularly true of this case, where there were no opportunities for the defence expert to inspect the mine, and witness evidence was the main opportunity to examine this area. As was discovered, it was also the only way that the holes in the crown case could be exposed, and the defence case could be established. As can often occur during criminal cases, there can be pressure on the parties involved to agree evidence. This case acts as a warning that a cautious approach must be taken; by agreeing evidence, there will be a missed opportunity to have certain witnesses cross-examined which can be extremely detrimental to a case. In this case, a timetable was agreed at the outset and adhered to, in order to allow for all witnesses to be heard. Finally, the case highlights the importance of interviewing all witnesses very carefully, in order to ensure high quality statements are available when building a defence.

In terms of the 2007 Act and what this tells us about cases going forward, it still leaves many questions unanswered. It bears striking resemblances to the approach taken in the old common law manslaughter cases, rather than setting a precedent under the new test of the need for senior management involvement – but not necessarily that of the "controlling mind" of the company. It does however highlight that as we are increasingly seeing, every effort is being made to hold individuals accountable where there are deemed to be health and safety failings. Interestingly, no health and safety charges under the Health and Safety at Work Act 1974 were

included in the charges – the crown's approach seemed to be that if they could establish gross negligence on the part of the mine manager, then they would succeed with corporate manslaughter against the company.

The case was conducted by Prashant Popat QC, of Henderson Chambers for the company and Elwen Evans QC and Owen Williams for the mine manager. A determination to explore in full the facts and circumstances of an incident can undoubtedly yield results for defendant and defence team alike.

Corporate Manslaughter Update: Summary

MNS Mining represents the eighth case to arise from the 2007 Act, yet only the second to result in an acquittal. Whilst PS and JE Ward Ltd also succeeded in defending a corporate manslaughter prosecution, the company was found guilty of an offence of the 1974 Act. One potential explanation for this high conviction rate is the tendency of previous companies to plead guilty to the corporate manslaughter charge. This has typically been associated with charges for gross negligence manslaughter being brought against the company's directors or senior managers. Individual charges have been dropped following a guilty plea on behalf of the company. This behaviour is exemplified by the cases of Lion Steel Equipment Ltd, J Murray and Sons and Princes Sporting Club.

The advent of MNS Mining may bring a change in the approach taken by companies which find themselves charged under the 2007 Act. The case has demonstrated that the offence can be defended successfully - even where there is the additional pressure of a senior individual facing a charge of gross negligence manslaughter.

It is worth noting that in the recent cases brought against Sterecycle (Rotherham) Ltd and Cavendish Masonry Ltd, both companies have foregone the guilty-plea inclination of their predecessors and defended the corporate manslaughter charges. Cavendish Masonry is awaiting sentence and the trial of Sterecyle Ltd has been adjourned until October 2014.

Oil and Gas News

Oil & Gas UK Annual Health and Safety Report

On 20 June 2014 the annual Oil & Gas UK Health and Safety report (the "Report") was published. The report is a measurement of health and safety performance in the oil and gas industry, compiled from a range of indicators.

The report indicates that performance of the oil and gas industry has been mixed – progress has certainly been made in several areas, but some safety indicators have declined when compared to previous years. The Report confirmed that there was a 49% reduction in the number of reportable hydrocarbon releases over a 3 year period to March 2013, falling slightly short of the 50% industry target. However, while there was an overall decrease in the number of reportable releases, the remainder of the year saw an overall increase in the total number of releases.

Oil & Gas UK Health and Safety Director Robert Paterson commented that: "Despite the ongoing and encouraging decrease in major and significant releases over the last year – the industry is not yet where it needs to be. Industry, working closely with the regulators and the workforce through Step Change and other bodies, is refocusing attention on preventative strategies and programs to maintain and enhance momentum in this crucial area."

The Report also highlighted a slight increase in the frequency of reportable injuries and dangerous occurrences, reversing the trend of improvements that had been made over previous years.

Another area of focus is the weight of the workforce. According to the Report, the average weight of a man or woman working offshore is now more than 14 stone, compared to 12 stone in 1985. This statistic is of particular importance given the Civil Aviation Authority's recommendation that, from 1 April 2015, passengers who are not able to fit through a helicopter's push-out window emergency exits will be prevented from travelling.

Aviation safety was the focal point of industry concern in 2013/4, and Mr Paterson stated that:

"Many of the actions and recommendations arising from those reviews have far-reaching implications for our industry and our workforce. We remain determined to ensure these matters are addressed in a timely and effective manner."

The full report can be accessed at:
http://www.oilandgasuk.co.uk/Health_Safety_Report_2014.cfm

EU Directive 2013/30 on Offshore Safety

On 28 June 2013, EU Directive 2013/30 on the safety of offshore oil and gas operations and accompanying environmental Directive were published in the Official Journal of the EU. On 18 July 2013, the new Directive on the safety of offshore oil and gas operations came into force for Member States – leaving them the task of transforming it into national legislation.

The Commission's view is that the EU has adopted the Directive as being EEA relevant and it therefore also applies to Norway. Following suggestions by the Norwegian authorities that the Directive did not affect them, it is suggested that there are to be further discussions in due course. In any event, the suggestion is made that the Directive has a lot in common with the Norwegian regulatory framework, so minimal change would be required.

A range of discussion has taken place, focussing on the extent to which these changes will reform the current regime in place in the UK. Being an EU Directive, rather than the Regulation initially proposed, the means of implementing the changes is left to Member States. The Directive sets out timescales for implementation which must be adhered to. This allows for at least some degree of flexibility; where there is currently adequate legislation in place, there will be no need for change. However where there are gaps or inconsistencies, additional legislation is expected.

A product of Deepwater Horizon, the Directive aims to ensure that best practices are implemented across all active offshore regions in Europe. Further, the Directive sets out requirements on licensees, operators and owners in relation to activity in the Union and outside of the Union. In November 2013, the Department of Energy and Climate Change (DECC) attended the Oil and Gas UK annual Environmental Seminar to speak about their expectations for implementation. They suggested at that stage that the changes stemming from the Directive will largely affect health and safety legislation, with amendments to some 16 regulations in 2014 to be expected.

A number of events followed, in which industry and the regulatory bodies have met to discuss the progress of the Directive. The scope for co-ordinating an integrated approach to safety and environmental issues offshore was recognised at the outset and a timetable for change was set out. Final draft Regulations are to be published by the end of November 2014, following a formal consultation which is currently underway (June – September 2014). Regulations are to follow, in order to meet the now tight deadline of 19 July 2015, by which time laws, regulations and administrative provisions must have been implemented.

Indications now suggest that the majority of the Directive will be transposed into UK legislation by amending the Offshore Installation (Safety Case) Regulations, with some amendment to other HSE and DECC legislation. DECC and HSE have made it clear that the approach to be taken would not involve "gold plating" (ie going beyond the Directive to achieve a "wish list") and a strict approach would be taken to amending only necessary existing legislation in order to implement the Directive.

Well Operations

However, there are still key issues that require to be ironed out in order for the industry to understand what impact the legislation will have on the UK's existing health, safety and environmental regime. For example, on 26 February 2014 at the HSE / DECC Workshop in Aberdeen, questions were posed at a public meeting with DECC and the HSE regarding the definition of "well operations". The importance of these questions stems from Article 42, where timescales for the application of the Directive are outlined under "Transitional Provisions". "In relation to owners, operators of planned production installations and operators planning or executing well operations, Member States shall apply the laws, regulations and administrative provisions adopted pursuant to Article 41 by 19 July 2016." In relation to existing installations, there is a later date: it is either the date of scheduled regulatory review or no later than by 19 July 2018.

In its current state, there is the potential for all UK offshore installations (over 300) to be caught by the earlier July 2016 transitional period. The lack of accompanying guidance to assist operators makes such issues all the more challenging. The HSE paper on the implementation of the directive, meeting date 21 May 2014, states that "HSE proposes to clarify the position in the new regulations so that the early transition dates only apply to specific well-operation requirements (e.g. submitting a well notification) and not to existing production installations where these well activities take place. Consequently, most of the production installations will not need to submit safety cases reflecting the new provisions before April 2018."

Operatorship

One key issue came to light it seemed almost by chance, during one of the many meetings with industry and DECC and HSE, with the potential for huge repercussions on the current structure of the industry.

The Directive states that "'operator' means the entity appointed by the licensee or licensing authority to conduct offshore oil and gas operations, including planning and executing a well operation or managing and controlling the functions of a production installation".

The existing position for health and safety is that the "operator" is defined in much the same way throughout all the relevant regulations, ie *"the person appointed by the licensee to manage and control directly or by any other person the execution of the main functions of a production installation."* In other words this only concerns the running of the installation (platform or FPSO) and only relates to safety, and the definition allows for licensees to appoint "another person" other than the licence/field operator to be the operator. DECC and HSE have since confirmed their joint position: that the "operator" of the installation is to be interpreted in a way which is more in line with the concept of "licence operator", than the one under health and safety legislation, that it will have to be approved by the licensing authority and would have to be the same company as the licence operator. They have proposed changes to the existing Safety Case Regulations and produced Draft Offshore Installations (Safety Case) Regulations 2015 – but strangely, have kept the same definition for installation operator.

Impact on the industry

At this stage, the potential impact of the changes to legislation is still unclear. However, if in fact the current position taken by DECC and HSE is realised, license operators will no longer be able to "contract out" duty holder or safety case obligations, e.g. to a "contracted out" operator.

There has been a flurry of activity on the question of operatorship which is set to continue, as this will impact the business model for many smaller operators and for some contractors providing this "duty holdership" service. Early experience during this state of transition is that both DECC and the HSE are taking a cautious approach and any change of operatorship is being scrutinised very carefully. In the meantime, the formal consultation period continues. The question is – is this really necessary? Licence operators do have health and safety and environmental obligations under existing legislation – and if the operator they have appointed for the installation turns out to be incompetent or under-resourced, duty holdership would revert to them in any case.

Health and Safety – what we do

CMS Cameron McKenna is recognised as a leading firm in the area of Health and Safety. We provide specialist advice on regulatory compliance, prosecutions, investigations and corporate governance. We have specialised knowledge of the offshore and energy sector in particular, which faces greater challenges and regulation than most.

However, our client base and expertise spans a broad range of sectors, including:

— Construction
— Health and Healthcare
— Energy
— Global Health and Safety Advice
— Hotel and Leisure
— Manufacturing
— Renewables
— Transport

Regrettably, accidents at work can be serious and sometimes result in fatalities. Our clients appreciate the high level of attention and support we are able to offer during what can be a difficult time for any organisation. We are able to provide assistance with every aspect of incident response, including incident investigations, dealing with witnesses, defending prosecutions and advising senior management on relations with the Health & Safety Executive.

Emergency Response Team

Our specialist team is on call to provide assistance and respond to incidents 24 hours a day, every day of the year. Our team is qualified to practise in England, Wales and Scotland but also regularly advises clients in relation to international working practices and health & safety matters in other jurisdictions.

Our clients come to us for advice on:

— Emergency Response
— Health and Safety prosecutions
— Crisis Management
— Accident Inquiries
— Formal interviews and investigations undertaken by inspectors
— Corporate Manslaughter investigations
— Inquests and Fatal Accident Inquiries
— Appeals against Improvement and Enforcement Notices
— Compliance with UK and European regulatory requirements
— Drafting corporate Health and Safety policies and contract documentation
— Safety aspects of projects and property management
— Due diligence in corporate acquisitions/disposals
— Directors' and officers' personal liabilities
— Management training Courses
— Personal injury defence
— Risk management and training

Recent Experience

— Defending Health and Safety prosecutions of client companies.
— Appealing other types of enforcement action against companies (e.g. Prohibition Notices).
— Conducting numerous Coroners' Inquests and Fatal Accident Inquiries - including some of the most high-profile and complex Inquiries to have taken place in relation to offshore incidents.
— Obtaining the first ever award of expenses against the Crown in favour of a client company following a Fatal Accident Inquiry.
— Taking Appeals to the High Court of Justiciary.
— Taking Appeals on human rights issues to the Privy Council.
— Defending Judicial Reviews.
— Advising on forthcoming Health & Safety legislation.
— Assisting clients in consultations with the Health and Safety Executive and other regulatory bodies, including the Department for Energy and Climate Change.
— Advising clients in relation to Safety Cases, Corporate Governance issues and Directors' duties and liabilities.
— Undertaking transactional due diligence in relation to Health and Safety matters.
— Carrying out Health and Safety audits.
— Advising clients on incident investigation, legal privilege and dealing with HSE inspectors.
— Preparing and drafting incident investigation reports.
— Advising clients on media, public relations and reputational issues following incidents.
— Advising clients in the immediate aftermath of an incident and providing emergency response services.
— Advising clients in relation to protestor action and possible responses thereto.
— Successfully defending environmental prosecution.

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