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Newsletter

May 2014

Monthly Meeting 12 May 2014

We regret to announce that Tim Prestage, our long-serving member and Chair since the beginning of this year, has recently tendered his resignation. We extend our thanks to Tim for his sterling and invaluable contribution to BHSEA during his many years of service and wish him well for the future. Management Committee are currently reviewing this situation and we will advise members of future developments.

Mark Hoare opened the meeting and gave a warm welcome to all, especially to our new member David Callaby of David Callaby Associates. Mark also welcomed guests here today, including Rob Elliott from Walsall College, and Colin Tuck from Aston University.

Apologies were received from: Steve Parton, Chris Hopkins, Sarah Newman, Tony Hall, Neil Boon, Andy Chappell, Roger Caleb and Richard Habgood.

Mark then handed over to Glen Musgrove, the guest speaker for the day.

'Phoar ... what's that smell?'

Glen Musgrove, Safety Adviser
MOHS Workplace Health

Glen has worked within Occupational Health for more than 20 years as an educational safety advisor, working alongside occupational health advisors, technicians and doctors.

Today's presentation would focus upon Occupational Health, particularly with regard to the screening of employees, such as via annual tests for eyes, ears and lung function, to check for the onset of health issues.

Glen asked the audience how many of them were in the habit of conducting base line tests (only three hands were raised). Without screening for pre-existing health conditions at recruitment it is difficult to determine what health issues the employee is bringing to the new job as opposed to those which may develop. This could obviously have implications with regard to future compensation claims.

Glen then introduced us to the HSE website and the very detailed section regarding Risk Assessment. Towards the end there is a reference to a book that can be purchased to assist in Workplace Assessments. Glen's advice is to employ a specialist to carry out the assessments, as they will be far more experienced, knowledgeable and more up-to-date on regulations – thus saving time and expense in the long run.

Always take good advice about health surveillance from properly qualified people before you implement a programme. This will ensure the correct consents are obtained and there is no conflict with matters such as data protection.

Within Occupational Health there are three levels of specialist:

- the Occupational Health and Safety Technician (competent but not formally qualified),
- the Occupational Health Advisor (usually with a diploma in the subject) and
- the Occupational Health Nurse.

It is wise to check the role of the person you are dealing with and how qualified they are to address your problems/concerns.

The most senior of all is the Occupational Health Physician and it is imperative that you follow their advice. In a court of law, you would not want to be arguing against them as you are likely to be at a disadvantage.

Accurate record-keeping is vital. The law requires employee health records to be retained for 40 years. This is because there are conditions, such as asbestosis, and mesothelioma, where symptoms can present at quite an advanced age.

<u>Workplace exposure limits</u>

Sometimes it will be difficult to determine someone's exposure to a potentially harmful substance or situation. Wherever there is doubt, it is wise to re-deploy the employee. As an example, Glen referred to a pregnant young woman who could be exposed to a harmful substance. Exposure might be a lot less and

even zero, eg in the case of mutagens. For her safety, therefore, re-deployment may be advisable.

In 2006 new regulations were brought in. Rather than referring to employees who were "exposed" to harmful substances/situations, the wording was changed to those who were "liable to be exposed".

Why should we undertake Health Surveillance?

(i) an identifiable disease or adverse health effect may be related to the exposure;

(ii) there is a reasonable likelihood that the disease or effect may occur under the particular conditions of his work; and

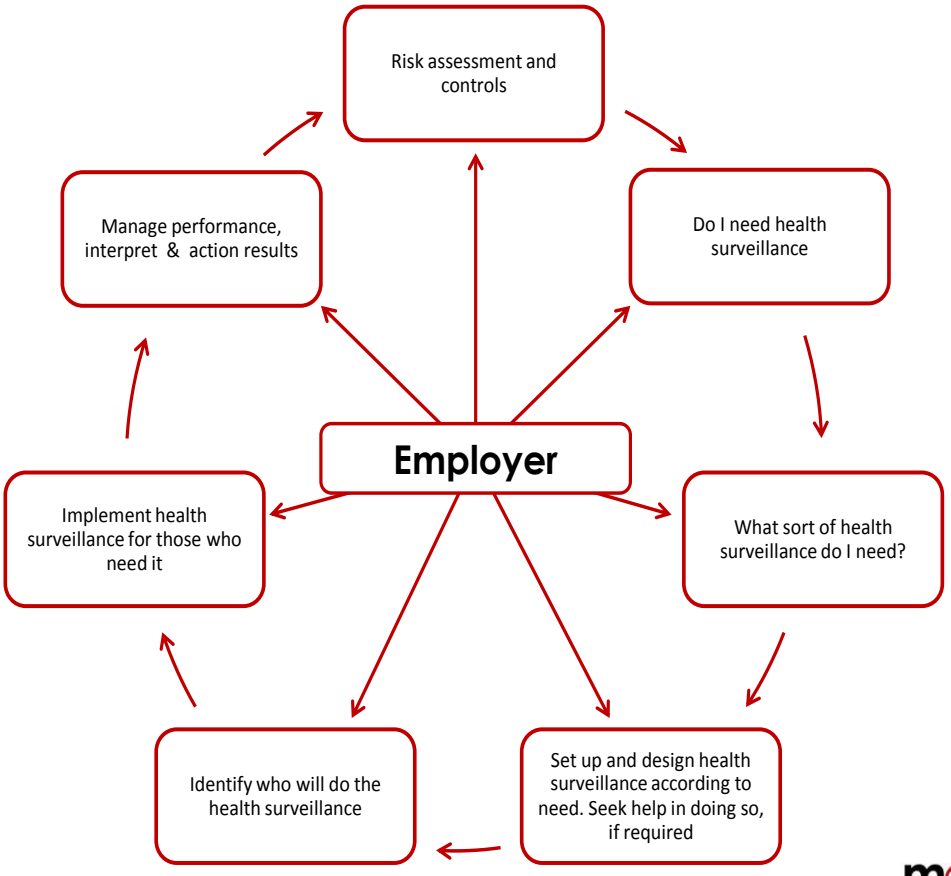
(ii) there are valid techniques for detecting indications of the disease or effect

When should it take place?

- 12 months
- High rate – as required (OHA advice)
- As required by relevant doctor
- Guidance e.g. Asthma / Silicosis / COPD
- Until exposure ceased

Bringing health to life

The health surveillance cycle



mohs workplace health ltd

How do we conduct Health Surveillance

- Examination by an OHA (Occupational Health Advisor)
- Questionnaires
- Lung function, eye and hearing tests
- Biological monitoring

Spirometry

Spirometry involves very complex equipment which needs specialist handling and accurate calibration. It is designed to work at temperatures above 17 deg Celsius. A reading taken below this ambient temperature is likely to be inaccurate and therefore useless. So the room must be up to temperature before testing commences.

Audiometry Tests

These are usually conducted in “sound-insulated” rather than “sound-proofed” environments. Only hospitals have the facilities to completely filter out all extraneous noise and provide totally sound-proofed rooms. Most testing facilities will be in mobile units. It is therefore important to site them in quiet areas, away from the noise of passing vehicles, which could give rise to misleading test results due to vibration.

There are concerns that noise exposure is not restricted to the workplace. Some people in particular are often guilty of playing car stereos at high volume, for prolonged periods of time, thus potentially permanently damaging their hearing as a result. However, some MP3 players apparently now have a built-in volume-limiting feature when played through headphones.

The industry standard for unacceptable noise is 85 dB(A). Anything above this is regarded as damaging. However, the RAF lowered their limit sometime ago to 75 dB(A) as they believe that above this level hearing damage can occur.

Vision

Snellen charts are still commonplace. However, there are now more sophisticated pieces of equipment. Some are less portable than others.

Drugs and Alcohol

It is essential to have a proper policy which includes issues such as consent, support, testing and discipline which gives you the tools to take action if someone turns up for work and you suspect they are under the influence of drugs or alcohol. Tests can be conducted on hair, urine, mucus and breath. Some tests have the ability to detect substances which were used/ingested up to six weeks before.

Case Studies

Glen then outlined two case studies with graphs that already indicated the normal parameters of a healthy person. The first was a 55 year old smoker and pattern maker who had worked in a foundry for some 12 years. His tests were

carried out with a Spirometer and the results recorded on the graph. They were significantly different from the healthy median.

Glen explained that screening is not a diagnostic service as it cannot be that accurate. It is a guide as to potential problems. A person could feel quite well although the testing process reveals them to have an underlying condition which they hitherto had no knowledge of. This condition may be in its early stages but the test results would provide an opportunity for the employee to visit his GP for further diagnostic tests and, if necessary, treatment. They would also enable the employer to review relevant risk assessments and to put in place safeguards, such as the provision of RPE (respiratory protective equipment), to prevent further deterioration of that employee's health, so averting long-term problems.

If the tests are inconclusive this will provide evidence of an employee's health at that point, should he go on to develop a health condition in the future. Bear in mind that the employee's lifestyle and previous employment may have contributed to his current condition. Part of the screening process involves a detailed questionnaire which, for example, asks questions which relate to the person's lifestyle.

Glen also explained that, although an employer had paid for the tests, they had no automatic right to receive any results. Detailed results would be provided to the employee, who would need to give his consent before anything could be revealed to his employer. Without written consent, the employer would only be told that the employee was fit or not fit for work.

Some companies, however, do explain to the employee that the consent form they sign allows the test to be carried out and also for the results to be passed on to the employer. If they are unable to agree to the latter, then the test will not be carried out.

Although there are less discreet surveillance companies, it is best practice that such sensitive health information be only disclosed to the relevant personnel within a company, who have a genuine need to know, and that the utmost confidentiality is maintained.

The second case study was for a 35 year old man who had been working in a foundry for 10 years and was suffering from noise induced hearing loss. The results of his tests suggested referral to his GP for diagnostic tests.

Glen's advice was that a company should be doing base line screening for anything that they are doing which may lead to health problems within their workforce. Whilst this can prove expensive, in the long run this would be more cost effective than having to deal with individual piecemeal compensation claims. (For example, in the case of British Coal Board and employees who developed Silicosis and submitted individual compensation claims.) A good start would be to screen apprentices as they are at the beginning of their working life.

Good occupational practice is overseen by the Occupational Health Physician. At a Technician's level they have a booklet which tells them what they can and cannot do when they do health surveillance. Competence is checked every year by a qualified member of staff.

Remember that an employer cannot be held responsible for any external activity that an employee undertakes which leads to a health problem, eg a person who has hearing loss as a result of frequent attendance at rock concerts. The main point is that an employer should make every attempt to control the workplace environment and put in place all the necessary safeguards and effective protective equipment to protect his employees whilst they are at work. If you as an employer are unsure, then call in an expert.

Bringing the session to a close, Mark thanked Glen for his excellent and most interesting presentation.

(Don't forget to check BHSEA website www.bhsea.org.uk for the slides covering today's presentation.)

Hot off the Press….

- First aiders warned about potentially faulty defibrillators
  First aiders in shopping centres, railway stations, dental surgeries and other public places were asked to identify if they have a specific defibrillator that could potentially give incorrect advice to anyone using it to give CPR to someone having heart problems.

  The defibrillator – called the samaritan® PAD 500P defibrillator made by Heartsine Technologies Ltd – has a software fault that may incorrectly advise the user to 'push slower' during CPR when, in fact, the CPR rate is at an acceptable level.

  For further information go to:
  http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON409284

- As part of "Tackling Occupational Disease - Developing New Approaches" the HSE has set up new pages on its web site that emphasise the importance that HSE places on the topic of Occupational Health. Visit:
  www.hse.gov.uk/aboutus/occupational-disease/index.htm
  The pages also link to a community site that promotes and shares the work that different organisations are undertaking to tackle the burden of occupational disease, including the work of SGUK and the Health Risks at Work initiative in providing an innovative approach to tackle long latency disease.

  Please see:
  http://webcommunities.hse.gov.uk/connect.ti/OccupationalDisease/view?objectId=214192

- Ray Johnson's TG20:13 Awareness
  A Comprehensive Guide to Good Practice in Tube and Fitting Scaffolding.
  Members may recall the presentation by Ray at our March monthly meeting. Ray has developed a certificated half-day course for managers, supervisors, charge hands and safety advisers who need to understand fundamental scaffolding requirements and the safety and quality aspects involved. For further information, please see the course overview on Ray's website www.safetyaccess.co.uk

Announcements:

Get these dates in your diary…..

- **SHADs 2014** (free events arranged by the HSE and BHSEA under the Working Well Together - WWT - Campaign):

TOPIC:	DATE:	VENUE:
Roof Works & Fragile Roofs	17 June 2014	Coventry Rugby Club (one for the girls!!)
Mock Trial	17 September 2014	Wolverhampton Science Park.
Worker Involvement	October 2014	TBC
Refurbishment & Occupational Health	18 November 2014	National Metal Forming Centre

BOOK NOW! Because places are limited!
Contact Dee Welsh at the HSE
Email: dee.welsh@hse.gsi.gov.uk Tel: 0121 607 6129

- **2014 BHSEA Programme Meetings - Dates for your Diary:**

9 June 2014 ***Legal Update/Open Members Forum*** BHSEA Management Committee. *Henry Skinner, ***Action on Hearing Loss.***	8 September 2014 ***Safety Software for Managers*** NEBOSH, ACT, Cardinus
13 October 2014 ***Construction–CDM & HSE Policies Update.*** Russell Adfield, HSE	10 November 2014 ***Respiratory Sensitisers*** Professor Sherwood Burge, Heart of England NHS.
8 December 2014 ***Face Fit Testing & Tight Fitting Respirators*** Alan McArthur, 3M PLC	

*Members' Corner Speaker.

- **June Meeting – Legal Update and Members' Forum:**

At the June meeting, Chris Hopkins, BHSEA Management Committee Member and Associate, Barrister for Pinsent Masons LLP, will be updating Members on legal matters and hosting a Members' Panel.

For the Open Forum/Panel session….Do you have a health and safety issue you would like to discuss with colleagues? Or a question to ask one of our expert Panel Members? Or is there something you just want a little bit of advice on? No matter how trivial….Email the Secretary with the issues you wish to raise before the 31st May.

- **BHSEA Members & Membership:**

Don't forget that the Membership target for 2014 is (at least) 330 Members. You can help promote membership by using your contacts. If each Member here today introduces ONE new Member, we could more than hit our target!

Date of Next Meeting

2.00 pm Monday 9 June 2014

at the Birmingham Medical Institute

Legal Update/Open Members' Forum

BHSEA Management Committee
Members & HSE

Members' Corner

Action on Hearing Loss
Henry Skinner

Don't forget the buffet lunch at 1.15 pm