

Birmingham Health, Safety



& Environment Association

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Newsletter

June 2015

Monthly Meeting – 8 June 2015

George Allcock opened the meeting with a warm welcome to all, including our guests today:

- **Chris Packham**, who is a partner in a small consultancy called Environment Services which is concerned with damage to health through skin exposure. Chris was keen to become a BHSEA member.
- **Graeme Saunders**, NSG UK Enterprises Limited, (Pilkington Automotive Ltd.), based in Kings Norton, Birmingham.

Extraordinary General Meeting

BHSEA Articles of Association:

Firstly, George discussed the background to the proposed changes. *(All Members were sent an electronic copy of the revised Articles of the Association, allowing them an opportunity to put forward their comments).*

The Articles, which set out the way in which the Association operates, were last updated 15 years ago. The reasons for the revision were to:

- 1) make the Association's objective more relevant for today
- 2) increase the number of Trustees from 3 to 4 to enhance BHSEA's democratic base
- 3) clarify the role of management (decision making) and council (advisory)

Association's objective:

To promote the health, safety, welfare and wellbeing of working people and the organisations they work for by facilitating, networking, sharing, learning, the adoption of good practice and continuous improvement.

This extends to an organisation's physical assets, the environment and the community which it serves or in which it operates, with a focus on Birmingham and surrounding areas.

Having been agreed by Council and Management, George then sought acceptance of the revisions to the Articles from Members present at the meeting.

Proposed: John Jones
Seconded: Lee Dargue
All were in favour, none against
The Articles were duly accepted

George thanked Chris Hopkins of Pinsent Masons for his key contribution to achieving the outcome.

It is a legal requirement that the Articles, and any subsequent changes, are promptly submitted to the Charities Commission and Companies House. Both have now been notified.

George then introduced the main speaker for the day:



Nicola Cárdenas-Blanco
Associate, Disputes Resolution Group,
SGH Martineau LLP

'Risk v Sacrifice: Myths and Realities'
(the concept of reasonable practicability)

Health and Safety: What is 'reasonably practicable'?

Nicola's current role is within 'Dispute Resolution' – the new term for litigation. The purpose of Dispute Resolution is to help organisations and individuals with regulatory issues – a large proportion of which are health and safety related, specifically falling within Sections 2 and 3 of the Health and Safety at Work Act.

Nicola has found that the most frequently asked question is ***"Am I okay to do this?"*** The aim of the presentation was to discuss the components of what is considered 'reasonably practicable' and offer some practical tips to help you to decide. In doing so, Nicola would refer to past events, current practice and consider what may lie in the future.

The Past

A significant event occurred in 1949. This was the year of the case of

Edwards v National Coal Board, in which the Court of Appeal enshrined the term of ‘reasonably practicable’.

Facts

Mr Edwards was killed when an unsupported section of a travelling road in a mine gave way. Only about half the whole length of the road was shored up. The Coal Board argued that the cost of shoring up all roads in every mine was prohibitive when compared to the risk.

Reasonably Practicable

The question at issue was not the cost of shoring up all roads in every mine operated by the company. The issue was the cost of making safe the section of road that fell. Some roads are secure and show no signs of failing. Others may already have fallen and have already been repaired. The section in question was already supported by timber along half its length. The cost of making it safe was not great compared to the risk of injury and loss of life.

The Court said that:

“ ‘reasonably practicable’ is a narrower term than physically possible ... A computation must be made by the owner in which the quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed on the other, and that, if it be shown that there is a gross disproportion between them – the risk being insignificant in relation to the sacrifice – the Defendant’s discharge the onus on them.....”

From that case we can see that the idea came about of the quantum of risk: **risk versus sacrifice**. This led to a focus on:

- looking at the risk
- deciding how serious the risk was, and then
- taking action: spending time, money and effort to try to avert that risk.

What the Edwards case did, however, was to set a standard. It placed parameters and guidelines on the exercise of that judgment.

Risk v Sacrifice became the main consideration in protecting people at work and in 1974 the concept of ‘**reasonable practicability**’ became a key component of the Health and Safety at Work Act (the legislation which underpins and affects the thousands of decisions made by safety professionals every day).

Perception

When we make a judgment on whether something is ‘**reasonably practicable**’, our thought processes are affected by our own individual experiences and

perceptions. Our past experiences will have a bearing on our perception of what may occur in the future. As we are all individuals, our past experiences will be different and we will attach importance and emphasis on different things - and so our expectations will be equally unique. This past experience, however, often helps us to conclude the best course of action.

Nicola explained that what is often trickier is when the situation is unknown to us, where we do not know the likely outcome and where there are a number of variables such as the size and type of organisation in question. What may be 'reasonably practicable' within a large organisation may be totally inappropriate in a smaller organisation.

Cost

Remember that it is Risk versus **Sacrifice** - which is defined as involving a number of elements, of which cost is only one.

Approved Codes of Practice

ACOPs, which are mostly sector specific, are very useful guides when determining the right thing to do. The law tells us what we have to do but not how to do it. Always check whether there is an ACOP available for your particular situation as it could prove to be invaluable. Although they don't carry legal obligations as regulations or Acts of Parliament do, if one is available and you have not complied with its guidance then the onus will be on you to demonstrate that you complied with your legal duty in some other way. If, however, an ACOP does not exist then talk to competitors, peers and organisations such as BHSEA for their views.

Weighing up the Risk

The measures you put in place will also depend upon the severity of the risk.

Where the risk is serious but not life threatening, a Risk Assessment will be the next step. Bear in mind though that this will always reflect the judgment of the person doing the assessment. But a matrix which identifies low, medium or significant hazards against likelihood of occurrence is a good starting point.

You do need to exercise proportionality. Where there is a gross disproportion between a risk and a safety measure, perhaps there's an argument for not implementing that measure. Although in the case of a prosecution a Court will not look favourably on an organisation that has simply put profit before safety. When deciding what factors you need to put in place, the health and safety factors weigh more heavily than cost.

Health and Safety Executive (HSE) Viewpoint

The HSE make an assumption that a measure is automatically 'reasonably practicable' unless its costs are **grossly** disproportionate to the benefits and that you will adopt that measure unless you can prove it is grossly disproportionate.

The unique drafting of health and safety legislation effectively says that you are guilty unless you can prove you took all reasonable measures.

The existence of an injury or incident is proof that an accident happened. In order for the company to prove that it is not guilty of having breached its duty of care it must be able to utilise the due diligence defence to avoid prosecution. Although “guilty unless proven innocent” is at odds with article 6 of the European Convention on Human Rights, the Courts have deemed this approach of the Health and Safety at Work Act to be fair. Because people have chosen positively to undertake a particular course of action they are therefore taken to assume the risks of non-compliance.

So Far as is Reasonably Practicable (SFAIRP) and As Low as is Reasonably Practicable (ALARP)

Nicola confirmed that the duties of ensuring health and safety SFAIRP and reducing risk ALARP are two terms that are not interchangeable but the HSE considers that they call for the same set of tests to be applied. However, legislation will determine how the tests are employed.

When deciding whether a particular measure was adequate the HSE will take into consideration the nature of the hazard, the extent of the risk and the control measures adopted. The more systematic a company’s approach then the more rigorous and transparent it will be for the regulator and other interested parties. It is, however, the view of the HSE that duty holders and the regulator should not be overburdened if such rigour is unwarranted. The greater the initial level of risk, the greater the degree of rigour required of the arguments to demonstrate that those risks have been reduced ALARP.

It is a question of proportionality and making a common sense judgment, based upon the level of risk and what is appropriate for your business to do in order to manage or eliminate the risk.

Some Case Examples

Brown v Grosvenor (2009)

In this case there was no **appreciable** risk and therefore it was not reasonable to expect the employer to take any particular steps.

R v Porter (James) (2008)

This was a case of a young boy who fell down steps whilst at school. He was hospitalised but then contracted MRSA in hospital and died.

‘Material Risk’: In this case the Court looked at the risks that you can appreciate and take steps to guard against. The law does not aim to create an environment that is entirely risk free; it concerns itself with the risks that are material.

Chargot 2008

Sections 2 and 3 of the Health and Safety at Work Act set out to keep people safe. However, they do not prescribe the means to achieve these results. They impose duties on employers who might reasonably be expected to accept the general principles on which those sections were based and to have the means of fulfilling that responsibility.

The prosecution in the case of Chagot 2008 in the House of Lords had to prove that the result had not been achieved. The onus was upon the Defendant to show its defence under Section 40 on the grounds of reasonable practicability. Placing the legal burden of proof on the employer is not disproportionate as by actively deciding to undertake a particular activity the employer must accept the risk of prosecution if they do not do so safely.

Existence of an injury is not in itself sufficient to demonstrate a health and safety risk. But it will lead to the need to identify and prove the respects in which there had been a breach of duty. That is likely to require evidence of a particular risk that had arisen. This requires analysis of the facts. The jury in this case only needed to agree about the results that the employer had to achieve or prevent – not on every aspect of the evidence.

(Chagot also said that in a prosecution under Section 37 (where there has been consent, connivance or neglect on the part of a director or company officer) there was no fixed rule as to what had to be proven to establish that an officer's state of mind amounted to consent, connivance or neglect.

Where the officer's place of activity was remote from the workplace, or what was done there was not under his immediate direction or control, quite detailed evidence might be required, of which fair notice would have to be given. Where the officer was in day to day contact with the place of activity, little more than what was required to establish a breach in Sections 2 or 3 might be needed.)

In light of the above examples, it is worth bearing in mind when you are making that judgment call just how you would justify your actions if questioned.

Consider the following questions:

- How significant is the risk?
- What could happen if I do nothing?
- What can I change – processes, people, resource, time, equipment?
- Has the risk been lowered?
- Is it as low as it can go?
- What else could I do?
- What are my peers/competitors doing?

This is the **reality**.

The **myth** is that you have to eliminate all the risks.

Finally – The Importance of Documentation

Nicola reminded us that documentation is key. It is essential to keep accurate records of what you identify and the measures you take. Over time, review and evaluate processes. Be systematic, sensible and logical. Take advantage of tools available, utilise experience and exchange ideas with peers. Above all, take proactive rather than reactive advice.

Remember that a court is comprised of people who in turn will be looking at your judgment call from a human point of view so a common sense approach is what is largely embraced. If in doubt go back to basics.

Questions

Q Colin Packham. Colin stated that under the COSHH Regulations a hazardous substance either has to be eliminated so far as is ‘reasonably practicable’ or else adequately controlled - which suggested that the term ‘reasonably practicable’ did not relate to adequate control.

A Nicola answered by saying that ‘reasonably practicable’ is an umbrella term enshrined in the Health and Safety at Work Act. However, what is outlined in the individual Regulations will determine the controls required as they will have differing standards dependent upon the risks involved. As a quick ‘aide memoire’ of those standards, Nicola suggested listing the regulations on an A4 sheet of paper and then summarising alongside what the tests might be.

Q Mark Hoare stated that risk assessment and the term ‘reasonably practicable’ was based upon a ‘significant risk’ but asked what the definition of significant risk was bearing in mind that every environment is different.

A Nicola’s view was to ask “What would be the level of harm caused to people, property or the environment as a result of a particular act or scenario happening?”. If the answer is above and beyond what you would normally expect in a day to day environment, leading to considerable changes, then this would be deemed a significant risk.

Q Lee Dargue stated that the HSE, rather than trying to eliminate every risk within the workplace, appeared to be directing people to focus on the bigger risks and away from the trivial, to which Nicola agreed.

Q Ralph Weaver raised a query under CDM Regulations 2015 as to how culpable the Principal Designer (PD) is likely to be in terms of ensuring, so far as is ‘reasonably practicable’, the design is safe and whether or not the PD would be responsible for ensuring all the companies in the supply chain were in compliance.

A Nicola advised that if the Regulations state that the Principal Designer has specific duties then the PD must be able to satisfy themselves that the required measures have been taken to avert that risk. This may, indeed, require going through all the paperwork of the other companies, although this could be quite an onerous task.

George Allcock recounted a similar experience from the past where his employer, in order to reduce costs, was closing down the central functions responsible for overseeing contractors. As a result, the company became reliant upon the contractors having processes and control measures of their own in place, which may or may not have been the case. It could then be an almost impossible task to establish all the facts if anything went wrong.

In George's view, a better approach was to undertake a capability assessment **before** appointing a contractor in order to determine the quality of their processes and also review past performance which would give some guidance as to their likely future performance.

Q Anu Spratley raised the subject of the change in strict liability for employers and asked whether Nicola had come across any new cases as a result. For example, in the case of personal injury the change meant that the onus was now on the injured party to prove negligence on the part of the employer.

A Nicola advised that these particular personal injury cases are normally dealt with in the civil court, rather than the criminal court which determines whether an employer has breached their duty of care. However, she pointed out that a guilty verdict in the criminal court does not necessarily mean that the injured party has a civil claim for negligence. They are completely separate.

Q Another Member asked whether Nicola was aware of any records being kept where HSE lose prosecutions.

A Nicola replied that there is a prosecutions database on the HSE website (<http://www.hse.gov.uk/>) where they publicise all of the details of the cases.

In conclusion, George Allcock aired the question as to whether or not the law is the best place to look for guidance as to what is 'reasonably practicable' as it is quite possible that a risk could be regarded as potentially having a serious outcome but, at the same time, the likelihood of that happening is so remote as to be not worth the cost and trouble.

Instead, George suggested looking at what others in your business and industry are doing to enable you to determine best practice.

George thanked Nicola for her informative presentation.

Nicola's presentation slides are available on the BHSEA website (www.bhsea.org.uk).

Members' Questions

This is a new item within the monthly programme meeting, where we will aim to discuss health and safety questions that have been raised by Members seeking the views of other safety professionals. If you have any questions of this nature then send an e-mail to Liz (secretary@bhsea.org.uk).

Mike Thurman had such a question on the day. He had been on a construction site recently where the site manager told him that an HSE inspector had been on site giving out instant fines to operatives in accordance with their Fees for Intervention Policy. The fines amounted to £150 per item.

Neil Boon stated that no operatives could be fined on the spot. This would have to go through the court process and also have to be due to a material breach. It would be the employer not the individual being fined – unless they were self-employed.

Other News and Announcements

Subjects for 2016 Programme

We are looking at possible subjects for the 2016 programme of meetings. If Members have any thoughts on topics they would like to see discussed, then please send your suggestions to Liz.

One member suggested a meeting covering the practical application of Risk Assessment.

Members' Corner Volunteers

We are also looking for more volunteers to do a 10 minute Members' Corner slot on the issues and challenges you have faced within your business.

BHSEA President

We are looking to recruit a President, an Ambassador, who will promote the aims and objectives of the Association. This would ideally be someone who has previously held a very senior position. A 'skills analysis' has been drafted. For further information please contact the Secretary.

Feedback from the Construction Event at the Barclaycard Arena

Neil Boon reported that there had been a good deal of positive feedback following the recent construction event - which was attended by just under 300 people - especially with regard to the good variety of speakers. The event was a credit to everyone involved and to BHSEA. See *BHSEA website for speaker biopics / presentations etc.* (<http://www.bhsea.org.uk/2015symposium.htm>.)

The WWT SHAD on 7 July at Coventry Rugby Club, subject 'Excavation Safety' was a resounding success, with over 120 delegates. Presentations from the Event will be on the BHSEA website shortly www.bhsea.org.uk.

Members' Corner



**George Allcock,
Chair, BHSEA**

Engaging Leaders – Driving change

George based his presentation upon his extensive personal experience working for a number of businesses.

In George's view, having the right leaders in place is paramount for the success of a business.

Role of Leaders

Leaders:

- develop the mission, vision and values of the organisation and are role models of a culture of excellence
- are personally involved in ensuring the organisation's management system is developed, implemented and continuously improved
- are involved with customers, partners and representatives of society
- motivate, support and recognise the organisation's people

Good leaders will know:

- how the organisation's mission, vision and values - including HS&E policy - compares with actual practice
- what all parts of the business look like and whether they all positively contribute
- how health and safety performance compares with others
- what good (best practice) looks like
- what attributes / characteristics are key to achieving the HS&E policy / excellence (best practice)
- what needs improving and how
- **what they - and leaders at all levels - need to do**

In reality, most leaders do not know the answers to these questions.

George has many years of experience of observing good and bad practice, which he is always keen to share with colleagues. Below are examples of just a few of the methods George has found to be invaluable in achieving the desired results.

Health and Safety Inspections and Reporting

A powerful technique that George employed was to take along a camera rather than just a checklist to site. He was then able to capture an image of the hazards he encountered and subsequently bring those images to the attention of senior management who would not otherwise be able to visit those sites in person. George found that these images were more powerful than a report and would often result in swift action where required. The technique could also be used at improvement workshops in order to better inform site workers.

When reviewing those photographs George would ask several questions. Why did those failures occur? Was it due to:

- sub-standard acts / conditions?
- preceding events?
- equipment or control faults / failures?
- system failures?
- leadership and management failures?

Characteristics of Excellence – What does ‘Good’ look like?

George showed a slide to highlight good and bad practices. Those practices more conducive to getting results are indicated below.

- Visible senior management **leadership**
- Supportive **culture**
- People - real **involvement**, team working
- **Integration** of HSE/R into business process
- HSE/R built-in to **change management**
- **Risk management** (proactive / preventive)
- High standard of **housekeeping and visual management**
- Regular **audit, measurement and review**
- **Continuous improvement**
- Planned and structured **training** at all levels
- Active **objectives, targets and plans**
- **Ownership** by line management / everyone

Self-Assessment Tool

Another powerful method to improve standards of leadership is the Leadership Self-Assessment Tool. This encourages leaders to consider any weaknesses in their actions and behaviours and could form part of the leader's continuous professional development in discussions with their boss.

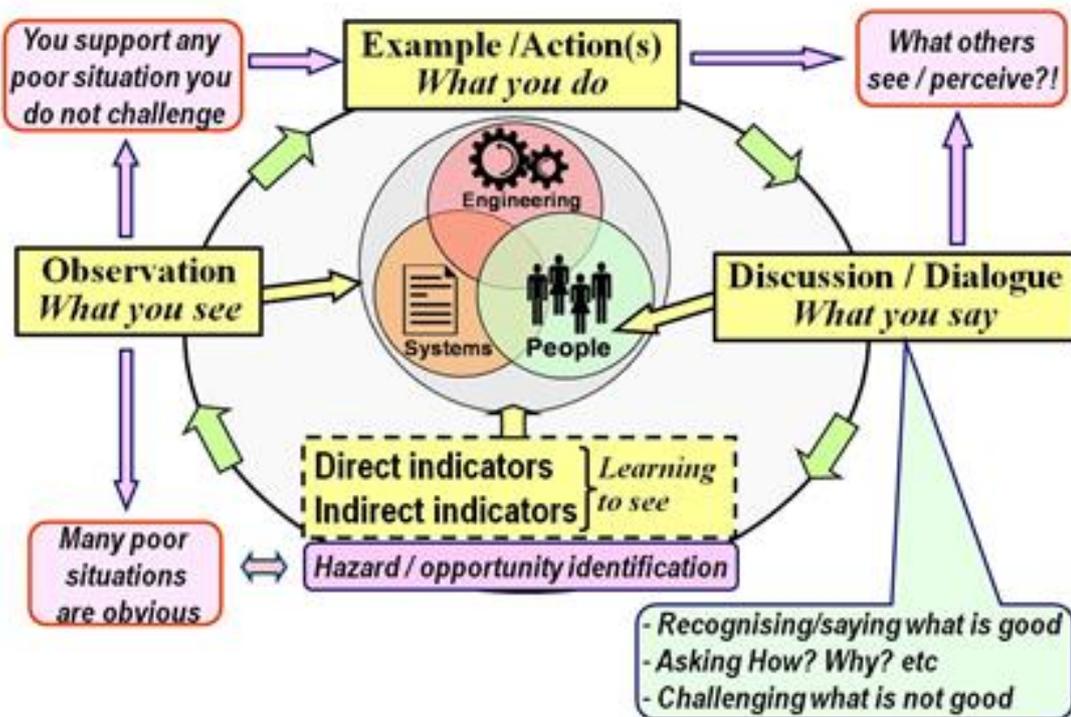


Leadership Self-Assessment

Health & Safety Leadership Self-Assessment						
Self-assessment by - name:	Position / Job Title:	Date:	Main things(s) I do		Key additional thing(s) I should do	
<i>Actual example name(s) removed</i>	manufacturing manager	8th March				
Reviewed by - name:	Position / Job Title:	Date:				
Leadership actions & behaviours	<div style="display: flex; justify-content: space-between;"> No - never No - not really Sort of Yes - sometimes Yes - regularly </div>				Example(s) of what I do	What else I could do
	1	1	1	1		
1 I recognise & visit all areas for which I have responsibility		1			walk site when possible	standard work to encourage more visits
2 I include H&S in the issues that I look out for & ask about			1		in all work i do i consider H&S impacts	
3 I challenge poor standards whatever they are & wherever they are			1		ask why when i see things	have more time to challenge when visiting
4 I am aware of, review & discuss safety performance incl. accidents & accident rate			1		review at weekly at level 3	
5 I talk with people - incl. shop floor - about H&S and other issues		1			attend occasional level 1 & 2 meetings	attend more MDW meets involved in tool box talks
6 I engage with all my people / colleagues not only when something is wrong			1			
7 I recognise improvements & achievements by giving positive feedback			1			
8 I review accident & audit reports, action sheets etc, ask questions & make comments	1				mainly done by (H&S Mgr)	
9 I engage with & support employees / teams in their improvement efforts / plans			1		mainly when requested	be more aware of what improvements and involved in plans
10 When necessary I remind people of Bridon policies, values & principles			1		at level 1 meetings	attend more level 1 & 2 meetings
11 I actively participate in H&S events incl. meetings, training, inspections & audits			1		involved when requested	
12 I demonstrate that H&S is a key value for (Co) & for me personally				1	always consider impact of H&S and aware of importance	

Sharing > Learning > Improving > Sharing > Learning > Improving >

And finally, a **Model for Leaders:**



Sharing > Learning > Improving > Sharing > Learning > Improving >

For George's presentation slides visit www.bhsea.org.uk.

SHADs: September to November 2015

Safety and Health Awareness Days (SHADs) 2015 West Midlands Working Well Together Group			
Topic	Date	Venue	Time
CDM / Temporary Works / Work at Height etc.	8 or 9 September (TBC. See BHSEA website for information.)	TBC	8.00-12.30
Managing Health in Construction <i>(BHSEA Programme Meeting)</i> Lucy McDonnell, Construction Health Risk Management Unit, HSE	12 October	Birmingham Medical Institute	14.00-16.00
Refurbishment, Loft Conversions, Temporary Works, Work at Height, Fire, Health and Welfare (TBC)	November (TBC)	TBC	8.00-12.30

Date of Next Meeting

2.00 pm Monday, 14 September 2015

at the Birmingham Medical Institute

Main Presentation

'So What Really is a Sprinkler System?'

Duncan McIntyre, Fire Protection Engineer, (Sprinklers)
AXA Insurance

Members' Corner

'New Sentencing Guidelines'

Chris Hopkins, Pinsent Masons LLP,
BHSEA Committee Member

Don't forget the buffet lunch at 1.15 pm