European Health and Safety Week

The annual European Safety Week, run by the European Agency for Safety and Health at Work (EU-OSHA), starts on 25 October and the theme is “safe maintenance”.

Commenting on the need for the campaign, Dr Jukka Takala, Director of EU-OSHA, said: “It is estimated that in Europe up to 20% of all workplace accidents are connected with maintenance and in a number of sectors over half of all accidents are maintenance-related. 10-15% of fatal accidents at work can be attributed to maintenance operations.” The Health and Safety Executive (HSE) points out that analysis of data from recent years indicates that 25-30% of manufacturing industry fatalities in Great Britain were related to maintenance activity. Not only can failure to carry out maintenance create hazards, but also those carrying it out can be exposed to a wide range of hazards, such as asbestos and falls from height.

The week aims to highlight many of the risks involved in both routine and reactive maintenance. The main objectives are to raise awareness of:

- the importance of maintenance for workers’ safety and health
- the risks associated with maintenance, and of the need to carry it out safely
- employers’ legal and other responsibilities to carry out safe maintenance
- the business case for doing so.

It also aims to promote a simple, structured approach to the management of health and safety in maintenance, based on appropriate risk assessment.

The HSE, in partnership with EU-OSHA, the manufacturers’ organisation, EEF, and the TUC, has launched the UK’s involvement in the campaign to encourage an integrated and structured approach to maintenance. Suggested activities include: showing an EU-OSHA slideshow on maintenance; raising the workforce’s awareness, eg with posters, campaign literature; trying the “safe maintenance health check”; entering the Good Practice Awards; and making others aware of the campaign and resources through e-bulletins, newsletters and e-mail.
Current developments

New safety advice issued on electric gates
The Health and Safety Executive (HSE) has published new safety advice on the subject of electric gates, following the recent deaths of two children.
On 28 June 2010, Semelia Campbell, aged 6, died when she was crushed by electric gates in Manchester. A few days later on 3 July, Karolina Golabek, aged 5, was also crushed to death by electric gates in Bridgend, South Wales.
While the police and HSE investigations continue into both deaths, the HSE does want to make it clear to installers that they must take action to prevent pedestrians from becoming trapped in electric gates.
Installers, designers, maintenance firms and manufacturers of electric gates are being urged to seriously consider the new safety advice, which points out that limiting the closing forces of gates alone will not provide sufficient protection to meet the relevant standards; installers must fit additional safeguards to gates in public areas.
The HSE’s Director of Field Operations, David Ashton, said: “When manufacturing, designing or installing electric gates, it’s crucial to consider who will be in the area when it’s operating. If the general public can access the gate, then additional protections should be in place.”
The HSE says these additional protections can be in the form of creating safe distances, installing fixed guards, limiting the forces or installing sensitive protective equipment, among others.
The new advice also reminds those in control of the maintenance of electric gates to regularly review their risk assessments, taking account of any changes to the operating conditions or environment.

Risk of Legionnaires’ from potting compost
The Royal Horticultural Society (RHS) has recently published advice on managing the risks of Legionnaires’ disease which are linked to potting composts.
The RHS says the risk of catching Legionellosis from the Legionella longbeachae bacterium in potting composts is thought to be “extremely low”.
Legionella pneumonophilia, associated with standing water systems, is a more common form of the bug and may also present a risk to gardeners in the form of irrigation systems, water storage tanks and water left in hose pipes.
Legionnaires’ disease presents the greatest risk to elderly gardeners and those with a suppressed immune system, but the RHS has offered the following advice on the subject.
The Society suggests that gardeners should wear gloves whenever handling soil, compost, fertiliser or pesticides. They should not open bags of compost or potting media with their head right over the bag and should avoid potting-up in confined spaces. Dry potting media should be moistened before use and, if possible, potting media should not be stored in greenhouses, as these will heat up and may encourage Legionella. Gardeners should consider wearing a dust mask when handling potting media or other dusty materials and when turning compost heaps, and should dampen down dry compost heaps before turning or use.
To avoid the risks presented by water systems, gardeners should: empty the water out of garden hoses after use and not leave full hoses in the sun after use; avoid splashing water around when watering pots; and keep water storage containers such as tanks and butts clean by emptying and scrubbing out once a year (they should be insulated to prevent temperatures increasing in warm weather or painted with a light colour to reflect the heat).
Gardeners should always wash their hands after gardening and especially before eating.
In addition, the RHS says that if the temperature of stored water for use in mist irrigation or sprinklers is above 20°C, it should not be used.
Current developments (cont’d)

Changes for pre-employment medicals

The Trades Union Congress (TUC) has published a new briefing document on the provisions of the new Equality Act 2010 and its implications for the use of pre-employment medicals, arguing that the use of such medicals to weed out applicants on health grounds will become illegal.

The Equality Act 2010 received Royal Assent on 8 April 2010 and the main parts of the Act are due to come into force in October 2010.

Concern that current legislation enables employers to discriminate against those with medical conditions during the recruitment process led to a clause being added to the Equality Bill, which seeks to prevent employers asking candidates questions about their health that are unrelated to the job role. The TUC briefing says that the changes introduced under the Equality Act 2010 from October 2010 will mean prospective employers cannot ask health questions of applicants “until the applicant has been able to successfully pass an interview, or some other assessment, to show that they meet some of the non-health requirements of the job”.

However, there are some exceptions, including questions designed to assess whether an applicant “would be able to carry out a core function of the job, with reasonable adjustments having been made as appropriate” and positive efforts to employ workers with disabilities.

Nevertheless, the corporate healthcare company, Blossoms Healthcare, argues that the Act does not mean employers are not at liberty to screen for health issues. A source at the company said: “Businesses are still entitled to screen people about health after the job offer. New entry medicals are a hugely sensible step, as they result in clarity about the need to make any reasonable adjustments, present a justifiable business case as to why an individual could no longer be employed, or establish a baseline health status.”

Management behaviour key to returns to work

New guidance on the successful return to work of employees who have been on long-term sick leave says that management behaviour is a key issue.

The guidance has been produced by the Chartered Institute of Personnel and Development (CIPD) in conjunction with the British Occupational Health Research Foundation, the HSE and the Healthy Working Lives campaign, and focuses on the key behaviours managers need to support successful and lasting returns to work after long-term absence.

It follows the recent introduction of “fit notes” to encourage those on long-term sick leave to make an early return to work with the support of their organisation.

The guidance is based on research involving employees, line managers, human resources personnel, and health and safety and occupational health practitioners. The research has led to the development of a competency framework to help employers equip managers with the necessary skills and a questionnaire designed to measure the relevant behaviours for managers. These include:

- staying in touch regularly with the individual while they are off sick
- reassuring them that their job is safe
- preventing them from rushing back to work before they are ready
- providing a phased return to work
- helping them adjust to the workplace at a gradual pace
- asking the individual’s permission to keep the team informed on their condition
- encouraging colleagues to support the individual’s rehabilitation
- holding regular meetings to discuss the individual’s condition and the possible impact on their work.

Health and Safety Management Newsletter

Health and safety considerations for working with offenders

Craig Jackson, Professor of Occupational Health Psychology at Birmingham City University, gives an insight to working with offenders, both within a custodial setting and outside it.

“Once a prisoner has been passed fit for a class of work, he renders himself liable to be placed on report if he proves idle and will then be brought before the medical officer to certify him fit to undergo punishment. It is therefore important that the prisoner is correctly assessed and passed fit only for work which is within his mental and physical capacity. We have to . . . ensure that no prisoner suffers injury through being ordered to do unsuitable work.” Director of Medical Services, Prison Commission, 1953.

Introduction

Offenders, those convicted of criminal offences, can pose a unique set of problems and difficulties for those routinely working with them. This article outlines the difficulties, along with the considerations needed to ensure good health and safety management for those workers, and the offenders themselves. The article is concerned with the interface of workers with offenders who are either in custody, or who are serving community-based sentences, which may pose two different kinds of health and safety risk to staff and offenders alike. Those who do not work in forensic or custodial settings may feel that interactions with offenders in their own line of work is highly unlikely. However, given the broad range of non-custodial community sentences available to the courts, it is quite likely that people will come into contact with offenders quite frequently in the course of their working routine, and often without knowing it.

It is necessary to understand the specific requirements of an offender’s community sentence as this may have implications for health and safety. Indeed, most people’s notion of what a community sentence involves will usually include the offender doing some form of unpaid work, closely supervised by a professional at all times. This is not always the case, however, community services can often involve the offender working unsupervised, and so the health and safety implications are not always clear.

The law provides for the courts to impose a community sentence on an offender. It can do this by sentencing the offender to a term of imprisonment (while suspending immediate imprisonment) and requiring the offender to be subject to a suspended sentence order. For less serious offences, the courts can impose a community order. Judges and magistrates are able to impose an order with one or more requirements, depending on the seriousness of the offence and depending on the potential risk of harm and risk of re-offending. Low seriousness and low-risk offenders may be sentenced to a community order with just one requirement. Higher seriousness and high-risk offenders may be sentenced to an order with three or more requirements.

Offenders can be ordered to do any of the following as part of their sentence:

• attend school
• take part in Community Payback — between 40 and 300 hours of unpaid work
• complete job training
• complete a treatment programme, eg anger management, rehabilitation for drug use or alcohol abuse
• avoid certain activity, eg visits to pubs or football matches
• comply with a curfew, often monitored by an electronic tag
• comply with a residence sentence: they must live at a specified place, such as a probation hostel
• receive mental health treatment
• complete a supervision sentence — requiring regular appointments with a probation officer
• carry out attendance training for 18 to 24-year-olds receiving help with criminal behaviour issues.
The variety of sentencing options available for offenders means that there are several types of workers who may come into contact with offenders, and these can be broadly categorised as those professionals who work in:

- custodial services
- offender management or rehabilitation
- those in neither of the first two categories who may just happen to encounter offenders in their job, eg a factory process worker who may (unwittingly) work alongside an offender on a community sentence.

Community sentences

Community Payback is a highly publicised scheme where unpaid work is carried out by offenders as part of their community sentences, mostly wearing bright orange jackets as they complete high-visibility work such as litter cleaning, clearing public land, repairing and decorating community buildings or removing graffiti. The high-visibility jackets were intended to emphasise to the public that the offenders were “paying back” for their crimes — up to 300 hours of unpaid work per offender.

Between April 2008 and March 2009, more than 100,000 offenders completed over 8 million hours of work. Local residents can make suggestions for community projects they want to see done by offenders serving community sentences, through the Probation Service. There is concern that offenders may engage in work that is dangerous for them if they are dispatched to various sites across communities, to locations that have not been risk assessed and they have not received appropriate training, or if they unwittingly encounter hazardous materials (eg cleaning community land that may be contaminated from illegal tipping).

Probation hostels, known as “approved premises”, are places where a court may require offenders to reside for a period of time. Hostels have a high level of supervision and security, and are usually equipped with CCTV and alarm systems, and may have strict rules and curfews, designed to keep offenders away from the people, places or activities that led them to commit crime. These domestic arrangements may have implications for the type of work that offenders can do, and a probation officer (assigned to all offenders on probation) will monitor the offender, in both his or her workplace as well as in general. Probation officers can also recommend that offenders get help for any emotional or behavioural problems they may have, and they can provide a useful way of ensuring support.

Case 1 — West Midlands Probation Board

In 2002 and 2003, the West Midlands Probation Board was served with two separate Improvement Notices by the Health and Safety Executive for two of its wood workshops, where offenders would attend to learn trade skills and engage in workplace rehabilitation. Notice 1 concerned the lack of any assessment under the Control of Substances Hazardous to Health Regulations 2002 for wood dust in a workshop, and notice 2 concerned the Provision and Use of Work Equipment Regulations 1998 for a bandsaw that was not secured to the floor in the second workshop. Both of these notices were complied with and improvements were made as required. This case highlights a central concern about the workplace rehabilitation of offenders — is there a social undesirability bias about offenders that allows society to accept a less than satisfactory level of health and safety where offenders are concerned? This is a contentious question that is still highly appropriate today.

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Health and safety considerations for working with offenders (cont’d)

for offenders suffering strain or stress in a workplace.

**Prisons and young offender institutes**

Prisons and young offender institutes (YOIs) are the locations where most offender-worker interactions occur. There are just fewer than 160 prisons and YOIs in the UK, with prisons in England and Wales alone currently holding 85,000 prisoners (as of July 2010). With many different categories of prison (maximum security, training establishments and satellite camps) there are many complexities in managing the health and safety of staff and offenders. An obvious problem is that those offenders wishing to commit unlawful and violent actions on fellow prisoners or staff do not follow rules or procedures, making it impossible to prevent such behaviour all of the time. Some ask if such complexities should make prisons immune from some aspects of health and safety legislation. Prison staff and others working in secure premises often feel they have a thankless task in this respect, and this receives little acknowledgment from the public. It has been suggested that the modern prison officer has to combine many roles including: prison lawyer, communicator, mental health counsellor, English teacher, manager, security expert, historian, health and safety advisor, rehabilitation counsellor, and drug counsellor.

Work plays a fundamental role in providing the valuable and necessary skills and qualifications that could help prisoners get a job on release. It should be remembered that work in prisons is part of the rehabilitation process, and not the punishment. As part of the induction process on entering prison, each prisoner’s suitability and preference for work is assessed. Throughout their stay in prison, prisoners’ achievements and needs are recorded and monitored to ensure that, as far as resources allow, each prisoner is helped to follow a constructive work plan. Training and education needs are considered and may allow prisoners to attain recognised qualifications such as National Vocational Qualifications, and the type of work available varies in each prison depending on the availability of resources and security and control requirements. Normally, work is available in industrial workshops or activity units. Work undertaken in these units is varied as much as possible and can provide skills in trades such as textiles, printing, engineering, data entry, woodwork, assembly, desktop publishing, and computer-aided design. Other work is available within the prison, such as catering, cleaning and general building and maintenance work.

The difficulty of protecting offenders from each other is virtually impossible in prison settings, as exemplified by Case 2.

**Case 2 — Prisoner assault**

A high-profile category A prisoner, serving two life sentences for double murder, with no prospect of release for at least 40 years, attempted suicide on three occasions during his sentence. In 2005, he was scalded by a fellow prisoner and sought legal aid to sue Her Majesty’s Prison Service (HMPS) for £15,000 for failing in their duty of care to him. Following a further attack with a razor blade by another life-serving prisoner at another prison in 2010, he sought almost £100,000 in a second legal attempt, again claiming that the duty of care provided by HMPS was not adequate. Although HMPS denied the validity of the claim, the case is yet to be heard.

Further, practical training is available in rural activities, fresh produce production, cropping, horticulture and landscaping, which can also lead to formal qualifications. Of historical interest, in 1953, HK Snell, the Director of Medical Services for the Prison Commission wrote: “There is also a considerable amount of work done outside the walls, including farm work, both attached to the establishment and for private farmers, and various parties work for the Local Agricultural Executive.
Committees on land drainage. There is no doubt that the employment of prisoners and inmates outside the walls in this way has done much to improve health and morale. This work has been accompanied by the development of satellite camps and open prisons and borstals which were first introduced to improve training but have also become necessary to relieve overcrowding. The benefits of such work have to be carefully balanced with the hazards and associated risks such as access to poisons, musculoskeletal issues, sharps and blades, and commonplace slips and trips.

Vicarious trauma

Ofenders with a diagnosis of personality disorder, or who have other complex behavioural or psychological problems, that are considered a risk to others are a current concern for public services. Provision for this offender group has recently increased, making it important to begin to learn about the needs of staff working in such a challenging area.

Some therapists working in prisons, who work with perpetrators of sexual offences, experience and report vicarious trauma (VT). Moulden and Firestone found such therapists describe a number of worrisome emotions, and have identified troubling effects, including intrusive thoughts, avoidance behaviours, and hyper-vigilance. In studies of VT in sexual offender therapists, researchers have found a history of previous trauma was not related to, nor predictive of, symptoms of VT in sexual offender therapists. Other factors, which were not related to VT included caseload proportions and treatment type. Some research has suggested that the length of time working with this offender population may contribute to trauma-reaction symptoms. Therapists early on in their careers and those with many years

of offender working were most negatively affected. In addition, sexual offender therapists working in secure and prison settings reported the highest levels of VT.

Conclusion

Preserving the health and safety of offenders that work and those who work with such offenders is an extremely complex task and is impossible always to complete perfectly. There are many types of offenders, present in a variety of secure and non-secure locations, coming into contact with other offenders, professionals, and members of the public. The range of effects of offender working can range from the physical to the psychological, even resulting in long-term trauma for those who just “do the work” without anything violent or threatening occurring to them.

Some recent and popular autobiographies of former prison officers have provided dramatic insights into the real happenings inside prisons, and more needs to be known about how working with offenders can have psychological and physical consequences for all concerned.

References


Snell, HK The Prisoner and His Work. A paper read at a meeting of the London Group of the Faculty of Medicine, Industrial Medicine Association on 24 September 1953.

Strategic planning and health risk management

Strategic planning for health risk management is essential to successful occupational health management. Jo Kitney gives guidance on preparing high quality and effective strategic health risk management plans.

Why plan?
Planning is a key element in successful health and safety (H&S) management. It involves setting objectives, identifying hazards, assessing risks, implementing standards of performance and developing a positive culture.

H&S professionals and managers are increasingly required to justify resource for, and demonstrate efficacy and value of, provisions for occupational health (OH). This requires more than just proficiency in managing health risks, but also an understanding of the wider business and management of an organisation or service.

Planning often focuses on addressing specific health risks, issues or OH activities. However, if it is to be truly effective and valued within an organisation, planning should also take place at a higher level and be linked to the wider management of the organisation.

Benefits of planning
Effective planning and the development of strategies for health risk management can both secure its position within an organisation and contribute to employee health and organisational success, by supporting the presence, performance and productivity of an organisation, its employees and contractors.

Higher level (strategic) planning determines where OH within an organisation is going, how it is going to get there and the expected outcomes and benefits. Importantly, it identifies, and can secure, the necessary management commitment and resource to achieve this.

Background information
Strategic planning is the process organisations undergo to define priorities and goals and make decisions on allocating resources to pursue this strategy. It is a critical element in articulating a shared vision, and for building the partnerships needed for stakeholders to work together on common goals.

The strategic planning process may be organisation-wide or focused on major aspects of its operation, eg the role or provisions of an OH service, with the aim of creating a common vision, a goal, objectives and milestones. To be effective, plans take shape through an iterative process of facilitated group discussions, research, drafting and review.

Key strategic questions
There is no “one size fits all” in the strategic planning process, but it should map a clear path between a present condition and a vision for the future. Areas of risk to success are analysed and specific strategies for overcoming those risks adopted. Generally speaking, the broad strategic concerns are as follows.

• What does the organisation offer or why is it needed?
• Where does the organisation currently stand?
• Where does the organisation want to go (or not go) and why?
• How does the organisation get there?
• How does the organisation know when it gets there?
• How can the organisation demonstrate it is there?

Business analysis techniques
There are many approaches to strategic planning, and recognised business analysis techniques include:

• strengths, weaknesses, opportunities and threats analysis
• political, economic, social and technological analysis
Strategic planning and health risk management (cont’d)

• socio-cultural, technological, economic, ecological and regulatory factors analysis
• environmental, political, informatic, social, technological, economic and legal factors.

The strategic plan
Having determined where an organisation is going, the strategic plan is developed to articulate where it currently stands, where it wants to go to and how it will get there.
The specific contents of the plan will vary between organisations, but will typically contain senior management endorsement, vision, key priorities and strategic objectives, long and medium-term goals and targets, timeline and arrangements for monitoring and periodic updates.
Revisiting the strategic plan to review accomplishments against documented objectives also establishes a feedback loop that can then influence future planning and decision making.

Strategic planning linked to health risk management
Strategic planning can be widely used within health risk management and applied to most circumstances, including business planning for OH services and provisions. Planning will identify key priorities and objectives and establish a roadmap of how this will be achieved.
OH management needs to be tailored to the needs of the individual organisation or business, its size, nature of the inherent risks, vision, key business drivers and obligations. Where there are shortfalls in effective management, the process of strategic planning can provide the necessary information to build a business case, as well as the strategic plan, to influence improvements in these areas.
The application of the key principles of strategic planning should ensure the planning process and soundness of the resultant strategic plan. Information on these key principles applied to health risk planning and the content of an OH strategic plan are detailed below, within the following three areas.
• Getting organised — key areas to consider include: scope of the strategic plan; target audience; timing of the planning; constraints and limitations; stakeholder support and involvement; information and documentation; commitment; resources; writing, marketing and implementation of the plan; factors for success and risk mitigation; risk identification; and collaboration tools.
• Strategic planning — this will be determined by the size and complexity of an organisation, its business and operations, health and safety culture, existing health and safety/OH arrangements, and resource and management commitment. Consideration must be given to: the vision; organisational culture; health risk profile and impacts; obligations and standards for practice; OH provisions; and health risk management practice.
• The strategy and strategic plan — effective health risk management strategies paint a vivid and clear picture and describe a bright future, with memorable and engaging wording. The strategy and plan will ideally be integrated within the organisation’s strategic plan and will typically include the following key elements: vision; values; priorities and objectives; goals; strategies; outcomes; measurements; and review.

H&S vision
A vision statement outlines what the organisation wants to be, or how it wants the world in which it operates to be, and can provide the direction to formulate a strategy and set goals and targets. Conversely, goals and objectives for H&S or health risk management can be summarised into a vision statement.
The relationship of H&S to the organisational vision will have implications for its strategy, and the nature of the H&S vision will have a profound effect on the scope of a health risk management strategy, its priorities and its effectiveness. A narrow vision (eg zero lost-time injuries) will support only a narrow programme of action. The health risk management strategy may need to influence an organisation’s vision in order to have full effect.

To define the vision statement for the management of health risks, two questions should be considered.

- What are the organisation’s aspirations for managing health risks and employee health?
- What can (and/or does) the organisation do or contribute to fulfil those aspirations?

Health risk management strategy and objectives
The strategy needs to target the key areas for improvement identified in the organisational health risk assessment and be consistent with the strategic direction, drivers and goals of the organisation. The strategy should recognise opportunities for change or improvement and will vary among organisations, eg different strategies would be developed where: the organisation is committed to best practice; competitiveness is a key business issue; human performance and employee contribution is critical; the organisation has a sustainability focus/agenda.

The following questions will be useful in articulating and refining the shared understanding of the vision and establishing the overall strategy and objectives.

- Strategy — What is to be accomplished? What is the boundary (project limit) of the achievements?
- Objectives — What are the short, medium and longer-term objectives? Is the strategy and end-state measurable? How will it be known when this has been achieved? Have objectives been prioritised? Which are most critical to the success of the strategy?

Goals, targets and KPIs
The purpose of articulating goals, targets and key performance indicators (KPIs) is to support the overarching vision and strategy. The emphasis is not on capturing all items associated with achieving this, and the KPIs should be well-chosen and purposeful to broadly demonstrate the following.

- Progression to the vision and strategic goal(s) — “the end-state”.
- Performance of health risk management.

Goals, targets and KPIs will be individual to each organisation and should be realistic and reflect circumstances. In developing these, it can be useful to consider the following areas.

- Lead and process indicators, eg create framework for management system.
- Impact and outcome indicators, eg behavioural change following training.
- Perceptual indicators, eg management and employee views on health risk management, personal protective equipment (PPE) and involvement in health risk management.

Strategies and outcomes
The strategic plan should contain details of key strategies that state how the organisation will achieve the overall strategy and objectives, and what outcomes can be achieved and by when. These will be broken down into more manageable and progressive parts. Generally speaking, strategic plans contain strategies and actions in the following key areas.

- The reduction in the number and severity of instances of workplace ill health, injury and incidents.
- The overall health risk (or workplace H&S) management system, eg the presence of an effective, reliable system to a pre-determined standard.
Strategic planning and health risk management (cont’d)

- The effective management of specified key risks, eg manual handling and falls from height or process-related risks, eg paint spraying and sewage work.
- The effective management of key processes that are seen as vital to the health risk philosophy of the organisation, eg team work and engagement or with the potential to significantly contribute to controlling health risks, eg design or PPE.
- Leadership and capability for health risk management, eg senior leadership and management/line management training.

The key outcome is something that is achievable within the resource limitations of the business and that has clear, allocated responsibilities and timeframes. Implementation details should be kept relatively sparse.

Different organisations will have different priorities and therefore different strategies and timelines for milestones. The following questions will assist in deciding on these.

- Where does health risk management want to be in the near term, ie one year from now and in terms of accomplishments? Where does it want to be in the long term, ie five years from now?
- What particular areas need to be addressed?
- What are the “quick wins” (things that are easier to accomplish than others)?
- What are the high profile items that can build momentum?
- Based on available time and resources, what is realistically achievable?
- What milestones or stepping stones are needed for progression? Will this be a phased implementation?

Measurement

Progress should be assessed frequently to ensure objectives are being achieved in a timely manner. Corrections to the strategy and plan may be required as new information becomes available or new opportunities, health risks or threats develop.

Measurement of performance should link to the overall objectives and to the specific goals, targets and KPIs, demonstrating progression to the vision and strategic goals and improved performance of health risk management. Key considerations for measurement are listed below.

- Who will be responsible for measuring progress?
- What are the critical success factors that would indicate the path to success?
- What data will demonstrate the benefits of the strategy and plan?
- What measurements of performance will be used?
- How will information be reported and to whom?

Review and updates

Strategic plans quickly become obsolete when no activity takes place to keep them alive. The most direct way to maintain a consistent focus on strategy is to hold regular strategy review meetings. At the end of the strategic plan formulation, a strategic governance process should be established where strategy review meetings are scheduled in advance.

To make the meetings productive, the health risk management leadership team should develop a standing agenda that can be consistently followed for each meeting. The strategy that was created at the beginning of the strategy planning cycle, along with progressive updates, should be the topic of conversation at every meeting, with no discussion of operational issues allowed. The necessary analysis should be prepared, and the findings circulated, before the meeting so that the session can be dedicated to guiding decision-making as opposed to conducting unbounded, unstructured discussion.
A safety manager has lost his appeal against charges brought against him following an electrical accident. He was originally fined £2500 plus £5500 in costs. The safety manager had overall responsibility for ensuring that risk assessments were conducted, for advising the company directors on safety matters and for preparing safety procedures. The company pleaded guilty to the related charges brought against it and was fined a total of £25,000.

Background

A flashover incident occurred when two technicians were installing a capacitor to help reduce energy consumption at a building in central London. One of the technicians was fitting cables in the back of the capacitor near a number of live conductors. One of the cables came into contact with a live conductor and a flashover resulted that caused burns to the technician’s face and upper body. He has been unable to return to work following the incident.

The safety manager was convicted of breaching s.2(1) of the Health and Safety at Work, etc Act 1974 (HSWA) by virtue of s.37(1). He was also convicted of breaching regulation 3 of the Management of Health and Safety at Work Regulations 1999 (MHSWR) and regulation 14 of the Electricity at Work Regulations 1989 (EAWR).

The company pleaded guilty to breaches of s.2(1) of the HSWA and regulation 14 of the EAWR.

Section 2(1) of the HSWA contains the general duty imposed on employers to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all their employees. Section 40 of the HSWA places the onus on the defendant to prove that they did all that was reasonably practicable.

Offences under the HSWA may be committed either by individuals or by corporate bodies. Section 37 stipulates that where an offence committed by a corporate body was committed with the consent or connivance of, or because of the negligence of, a director, manager, secretary or other officer, the director, manager, secretary, etc is also guilty of the offence and may be prosecuted in addition to the corporate body. This is in effect a double prosecution, as with the flashover incident. The company was prosecuted along with the safety manager as it was held that the safety manager was advising the company as to the procedures it should follow. Therefore, his consent, connivance or negligence led to the company breaching s.2(1) of the HSWA.

Regulation 3 of the MHSWR requires that every employer shall make a suitable and sufficient assessment of a) the risks to the health and safety of his employees to which they are exposed while at work, and b) the risks to the health and safety of persons not in his employment, arising out of, or in connection with, the conduct by him of his undertaking, for the purpose of identifying the measures he needs to take to comply with the requirements and prohibitions imposed on him by or under the relevant statutory provisions. The safety manager had completed a risk assessment for the work being undertaken, but it was deemed not to be suitable and sufficient.

The Approved Code of Practice supporting the MHSWR stresses that risk assessments should enable employers to identify the measures needed to comply with health and safety law. Further, the assessment should identify how risks arise and how they impact on those affected. This information is required in order to make decisions on how best to manage those risks. In this way, the decisions made are informed, rational and structured and the action taken is proportionate. By failing to complete a suitable and sufficient assessment, the safety manager made it impossible for rational decisions to be made concerning the necessary controls.

The Approved Code of Practice also casts light on what is meant by the phrase “suitable and sufficient”. Briefly, the risk assessment should:

- identify the risks arising from or in connection with the work with the level of
detail being proportionate to the risk then insignificant risks can usually be ignored

• consider relevant sources of information and examples of good practice
• be appropriate for the nature of the work and identify the period of time for which it is likely to remain valid.

Regulation 14 of the EAWR relates to work on or near live conductors. It stipulates that no person shall be engaged in any work activity on or so near any live conductor, other than one suitably covered with insulating material so as to prevent danger, that danger may arise unless:

• it is unreasonable in all the circumstances for it to be dead
• it is reasonable in all the circumstances for them to be at work on or near it while it is live
• suitable precautions, including where necessary the provision of suitable protective equipment, are taken to prevent injury. It is important to note that the word “work” is used and not “electrical work” as this extends the requirements to any work activity on or near live electrical conductors which may foreseeably give rise to danger. Regulation 29 contains the defence available in criminal proceedings, which is that the person took all reasonable steps and exercised all due diligence to avoid the commission of the offence.

The requirements of regulation 14 are clear in that if danger may otherwise arise it is always preferable, from the point of view of safety, to work on or near electrical equipment that has been made dead. Where work must take place near or on live equipment, suitable precautions will include: competent persons, provision of adequate information, use of suitable tools and instruments, use of suitable insulated barriers or screens, accompaniment and effective control of the area.

Failings

It was held that the safety manager failed to carry out a suitable and sufficient risk assessment and also failed to ensure that electrical power to the equipment had been isolated. The safety manager unsuccessfully argued that he had taken adequate steps to protect the technicians and that his risk assessment was sufficient and correct.

It was also held that the employees were merely instructed not to enter the live compartment where there was a high risk of accidental contact with live electrical conductors. Full electrical isolation would have removed the risk or installation of a non-conductive screen would have separated the technician from the live compartment. Finally, measures taken to minimise swarf collecting in the panel would have reduced the risk to an acceptable level.

The safety manager should have identified that these precautions were necessary and then taken steps to implement them in order to protect the technicians from harm.

Lessons learned

The case demonstrates that health and safety professionals are not immune to prosecution. According to the environmental health officer investigating the incident, the judgement highlights the duties and responsibilities of safety personnel in ensuring that the precautions identified are sufficient to protect employees from harm. Employees working under the safety manager’s direction relied on his advice in order to ensure their safety and, unfortunately, in this case that was something he failed to ensure.

Since the incident, a point-of-work risk assessment form has been introduced that must be completed before the start of each shift. In addition, engineers now wear flame-retardant overalls when working in switch rooms.

From a personal perspective, the safety manager stated that he deeply regretted the injuries that were sustained in the incident.
Questions and answers

Health promotion scheme

I want to persuade our senior management team to introduce a health promotion scheme at work. What arguments can I use and what factors must I consider when developing the scheme?

For a health promotion scheme to succeed, it is vital to have top management buy-in and involvement. This must go beyond endorsement of programmes and involve the active and visible participation of senior management.

Good arguments for introducing a health promotion scheme can be found in the research commissioned for the review of the health of Britain’s working age population. It found considerable evidence that health and well-being programmes produced benefits for both employer and employee. For the employer these include:

- reductions in illness-related absenteeism, fewer working days lost and a long-term decline in the sickness rate
- increased motivation among staff and improvement in the working atmosphere in the company leading to more flexibility, better communication and a readiness to co-operate
- measurable increases in the quality of products and services, more innovation and creativity and a rise in productivity in the company.

Recent evidence has also found that work is, on the whole, good for an individual’s health and well-being, and the reverse is true of worklessness. Through health promotion, the stresses and strains that can affect employees can decrease while their well-being and attitude to work can improve.

Clearly, establishing a health promotion programme may have costs attached. However, evidence provided to the review suggests that initial programme costs can quickly be translated into financial benefits, either through cost savings or additional revenue generation.

Any scheme or initiative must be aligned with the aims of the business. Management agreement should be obtained to integrate health promotion as a specific company target. The following must also be considered.

- The views of employees should drive the programmes and initiatives that are offered. It may be prudent to establish a working group that is responsible for planning and steering appropriate activities.
- The aims and objectives must be decided. Employees must be engaged with the process and any programme must take account of their needs and what they value.
- A workplace health promotion programme must be developed, it should include responsibilities for implementation through an action plan. Successful programmes are those that are specifically designed to meet employee needs.
- The promotion of the initiative. Communication is key in terms of employees being informed and updated on any health and well-being initiative.

Definition of a display screen equipment user

We have members of staff who occasionally operate our CCTV system. They say that they are display screen equipment users and must have an assessment carried out. Does CCTV come under the definition of display screen equipment and must we then meet the requirements of the regulations for those users?

To answer this question, reference must be made to the Health and Safety (Display Screen Equipment) Regulations 1992 and the guidance contained in L26. In the regulations, display screen equipment (DSE) is defined as any alphanumeric or graphic display screen, regardless of the display process involved.

Screens used at work with television or film pictures are now included in this definition.
This point was clarified in a recent European case. The court held that the idea of “graphic display” includes monitors for replaying film clips, so that work on monitors and the subsequent processing of digitalised film images is covered by the directive.

As such, L26 now states that a security control room operative whose main work is to monitor a bank of display screens showing the pictures from CCTV cameras, and operate controls to select, zoom in, etc on particular images, would be deemed to be a DSE user.

However, in this case, as the staff only periodically have to operate the CCTV equipment, it could be argued that they do not fall within the definition of a user, based on the normal criteria that are used to determine such matters (such as continuous use, daily use).

Even if it is decided that users fall outside the definition, it should be noted that in the foreword to the guidance document L26, the Health and Safety Executive (HSE) states that where DSE is used but such use is not covered by the DSE Regulations (because there is no defined “user”), the workers concerned are still protected by the Health and Safety at Work, etc Act 1974 and the other general legislation including the Management of Health and Safety at Work Regulations 1999.

It continues by stating that “where a display screen is in use but the DSE Regulations do not apply, the assessment of risks and measures taken to control them should take account of ergonomic factors applicable to DSE work”. It may be advisable, on this occasion, to carry out an assessment.

Defibrillator in public workplace

Our workplace is open to the public. It has been suggested that we should have a defibrillator because of this. What is the legal position on this and how do we decide if it is necessary?

There is no specific legal requirement for employers to provide defibrillators in the workplace. The Health and Safety (First Aid) Regulations 1981 require the employer to provide, or ensure that there are provided, such equipment and facilities as are adequate and appropriate in the circumstances for enabling first aid to be rendered to his employees if they are injured or become ill at work”.

As such, employers have no obligation to provide first aid for members of the public. However, many organisations provide a service for others and the HSE “strongly recommends that employers include the public and others on their premises when making their assessment of first-aid needs”.

The individual organisation is responsible for deciding whether to provide a defibrillator and train staff in its use. A decision should be made after conducting a well-documented risk assessment at the site in question. The HSE states that “there is no legal bar to employers making a defibrillator available in the workplace if the assessment of first-aid needs indicates such equipment is required”.

L74, the Approved Code of Practice to the First Aid Regulations provides guidelines on to factors to consider when assessing first-aid needs.

To supplement this, the Resuscitation Council has provided guidance. Important factors to consider when assessing the risk of cardiac arrest will include the number of people using a facility and the risk of cardiac arrest occurring at the site. Current international resuscitation guidelines advise that evidence supports the establishment of public access defibrillation programmes (with the installation of an AED) when:

- the frequency of cardiac arrest is such that there is a reasonable probability of the use of an AED at least once in two years
- the time from call out of the conventional ambulance service to delivery of a shock cannot reliably be achieved within five minutes (for practical purposes, this means almost the entire UK)
- the time from collapse of a victim until the on-site AED can be brought is less than five minutes.
Case law

**Bristol airport demolition death: £100,000 fine**

Rubb Buildings, a construction company, has been fined following the death of an employee during demolition work.

**Significant points of the case**

- In December 2006, Steven Watson, an employee of Rubb, was working to dismantle a hangar at Bristol airport.
- High winds at the time meant that Watson decided to work from the top of the hangar as there were concerns about metal parts of the structure being dislodged by the wind.
- The site supervisor, an employee of Fitzpatrick, a groundwork construction company, told Watson that he must wear a harness.
- Watson failed to wear a harness. He fell through a hole in the roof and died instantly from multiple injuries.

**Points in mitigation**

- The company had no previous convictions.
- It had entered an early guilty plea.
- It now has a new system for managing protective equipment and has renewed its method statement.

**Decision**

Rubb Buildings was fined £100,000, plus £48,000 costs, for a breach of s.2(1) of the Health and Safety at Work, etc Act 1974 for failing to ensure the health and safety of employees.

**Comment**

The Health and Safety Executive (HSE) investigation into the fatality discovered failings in the company’s work plan, method statement and supervision. The company was unable to produce inspection and maintenance records for the harnesses.

An HSE spokesperson is reported to have made the following points.

- The work could have been done from underneath, using a mobile platform.
- Rubb had not avoided work at height and did not follow the hierarchy of risk control.
- The deceased should never have been on the roof. When he was, he should have had the correct equipment and training. None of these was provided.
- The fine reflected new sentencing guidelines which state that fines for health and safety failings, which result in death should seldom be less than £100,000.
- The tragedy about the incident was that there was no reason for the work to be done from the top of the roof.
- Watson should have been properly protected by Rubb Buildings. Instead, he lost his life. The company had failed in its duty to ensure that there was a properly planned and supervised means of working.
- Falls from height could be extremely serious and adequate safety measures must be in place to protect all workers.