Future proofing the workplace HR conference - 27 April 2015

Health & Safety For All

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Health & Safety for all

- Health & Safety at Work Act 1974
- Health & Safety needs to be on the top of any agenda and reviewed regularly
- Risk assessments need to be carried out
- Investing in training is key

Issues we will be discussing

- What is reasonably practicable?
- Low/high risks
- Risk assessment
- Check list



 This includes staff, volunteers, members of the public on your premises and those at any event you may organise

Health & Safety at Work Act 1974 s.2

General overriding duties:-

 It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees

Health & Safety at Work Act 1974 s.3

It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected are not exposed to risk to their health & safety (s.3 of the Act)

Human Resources staff

 Human Resources staff are often the front line in dealing with Health & Safety issues

Issues to consider:

- Training
- Lone workers

Health & Safety tool kit

Risk management in HR

- Risks are inevitable. The key is identifying and managing those risks as far as possible.
- Specific focus upon risk management as it applies to HR activities
- E.g. Do we provide safe working conditions? Have safety checks been completed regularly?
- Have we provided adequate training for staff?
- Do we have adequate policy procedures in place?

Identifying the risks

 It is useful to involve staff, volunteers and board members to contribute to this process. They will give you a comprehensive picture of the risks from various individual's viewpoints

Risk assessment

- Every business is different and will require different risk assessments
- What you need to consider when conducting a risk assessment:
- Identify what the hazards / risks applicable to your business are. Speak to staff, walk around the office, look at your accident book etc.
- Identify who might be harmed and how
- Identify what, if anything, you are already doing to combat this risk

Risk assessment action

- Once you have identified what risks might apply to your business, you must identify what further action is necessary
- You should identify who is responsible for implementing the further action and when this should be completed by
- You should record when the action is completed
- It is sensible to review and update risk assessments annually

Thoughts on training and risk assessment

- Sharing information is key between agencies as well as other members of the team
- What training is in place to ensure that proper risk assessments are undertaken in relation to lone workers

Lone workers

- Risk assessments are vital
- Does the work place prevent a specific risk?
- Does the lone worker need to travel? How will they get there? Time delay – will it be dark?
- Is there is a risk of violence or aggression? Is there a safe way in and out?
- Training is particularly important for lone workers

Some examples of what happens if it all goes wrong

- Mental Health Charity fined for Health & Safety breach after employee death – 2010
- Mental health worker stabbed by paranoid schizophrenic
- Fine of £30,000 costs of £20,000



Support worker kicked by client – December 2009

- Charity prosecuted following the injury of support worker by a client suffering from learning difficulties
- Charity were aware of ongoing risk of violence and aggression but failed to consider safety of staff
- Charity fined £7,000 for breaching s.2(1)Health & Safety at Work Act
- Fined a further £7,000 for breaching s.3(1)Health & Safety at Work Act

 It is vitally important during a risk assessment to look at your surroundings. Look at the equipment that staff are using and look at the training that they receive You should inform people from the top to the bottom of the organisation what you have found. Once you have completed your risk assessment you then need to review the organisation's policies and procedures Some examples of what can go wrong when this process is not completed properly

Welsh care home fined following elderly residents death

- Cardiff Crown Court dealt with this matter. A 92 year old resident in a care home died as a result of a fatal fall
- Windows in the home were unsuitable for types of vulnerable people who would be using the building.
 Windows were fitted with restrictors but could be easily overridden which would allow windows to open wide.

Substantial fine

 The home pleaded guilty to one charge under s.3 Health & Safety at Work Act 1974 and was fined £96,000 and ordered to pay £100,000 in costs

HSE comment

Quote from HSE inspector:

"Falls from windows are a very well known risk in the health and care sectors. For example between 2005 & 2010 there were **21 fatal accidents** from this across the UK. It is therefore essential that measures are taken to ensure vulnerable residents are kept safe. They should carry out a risk assessment and where it identifies that individuals are at risk from falls from windows then adequate restrictors should be fitted"

Care home prosecuted over death of 40 year old mother of one

- This is a very sad story of a lady who suffered from Huntington's disease and was found unconscious in bed trapped between a mattress and a bed rail, which later resulted in her death
- Her condition made her prone to involuntary movements and so a specialist cushioning system was used along the bed rails
- Preston Crown Court found that the equipment was not used correctly by staff. It was found that staff had not been given proper training on the use of the equipment and, as a result, the lady died

Outcome

 The charity care home pleaded guilty to breaching Section 3 of the 1974 Act and were ordered to pay a fine of £35,000 and £65,000 towards the costs of the prosecution

HSE findings

- HSE inspector commented that the home was oblivious to the risks associated with this kind of equipment and they had **no proper risk assessments** in place. The maintenance of the equipment was also poor and staff were not **trained** to spot any problems which could have arisen, as happened in this case
- Must carry out regular risk assessments on all equipment to make sure the way in which it has been used is fit for purpose and continues to meet the needs of those using it

Prosecution after boy loses finger

- Charity received a conditional discharge and ordered to pay £898.00 costs following an incident at a school.
- Boy who had autism and learning difficulties lost an index finger having trapped it in a door.

Pensioner died after being thrown from a wheelchair on a mini bus

- An 88 year old lady suffered a head injury and broken neck after being thrown forward whilst travelling in a mini bus owned by a charity
- The mini bus driver had performed an emergency stop which resulted in the lady being flung from her wheelchair
- The lady died 2 months after receiving her injuries

- This is a case that was heard before the Old Bailey. A case such as this is bound to cause a significant amount of reputational damage as well as the tragic circumstances of a loss of life.
- The court were told that workers had not been given adequate training by the Charity to ensure that wheelchair users were safe whilst travelling in a wheelchair within the mini bus.

The charity were fined £10,000 and ordered to pay £5,000 costs for breaching s.3(1) Health & Safety at Work Act 1974

Employer sentenced after elderly worker crushed to death

- Worker aged 69 crushed by gates
- He opened a double set of gates using his key. One of the 180 kilogram gate came off it's hinges and fell on top of him
- HSE inspector commented:

"Employers have a duty to provide and maintain a safe means of access and egress for their employees. This tragic death could easily have been prevented had the gates been installed and maintained properly. Unfortunately this failing led to a loss of life"



- The HSE found that the gate had been catching on the ground when it was opening. The use of the washers meant that nothing could be used to secure the hinges in place and once it caught on the ground there was nothing to prevent the gate from falling from its hinges
- HSE inspector commented 'Employers have a duty to provide and maintain a safe means of access and egress for their employees. This tragic death could easily have been prevented had the gates been installed and maintained properly. Unfortunately this failing led to a loss of life'

S.2(1) Health & Safety at Work Act 1974

- Company fined £20,000 following a guilty plea for breaching s.2 Heath & Safety at Work Act 1974
- 'It shall be the duty of every employer to ensure so far as is reasonably practicable the safety and welfare at work of all his employees'
- This is an example of an every day issue that you could face. It might be that there is a defective gate or door that you simply never get around to dealing with or because of lack of funds you do not address the problem. This is an extreme example but a good example of how those types of simple failures can end in a very tragic accident

What do you do once you have completed your risk assessment

This is an ongoing process..

- Having evaluated the risks you need to explore the problems and develop solutions
- How likely are particular issues to occur?
- What is reasonably practicable? What are the low/high risks?
- Record your findings and reasons for developing and implementing action plans

Developing an action plan

- Need to give actions in order of priority based upon the likelihood of the risk occurring
- Allocate resources in light of the above
- Who is going to be tasked with ensuring the actions are carried out?
- What is the time scale?

- You must inform people from the top to the bottom of the organisation of your findings
- You must monitor and review the action plans and assess effectiveness. You need to be flexible as and when the organisation changes and roles change

Once you have completed your risk assessment you then need to review the organisation's policies and procedures to establish whether or not they adequately reflect the way in which the organisation is currently working. Note that changes occur throughout a period of time and what may have been adequate previously might not be now

Points for discussion

Questions??

