

Case Study 1

Main concerns about H&S in the work of a **Scenes of Crime Officer**

1. Inhalation of metallic fingerprint dust, specifically aluminium - a basic type of 3M face mask for nose and mouth is issued but there is lots of scope for contamination, eg touching & readjusting during wear, so a mask is soon dirty with powder and the powder on the mask is in close proximity to the wearer's nose and mouth. I think there would be raised eyebrows if I were to ask for a fresh mask for each incident I attend where I use powder. Wet wipes for cleaning my hands between jobs remove some of the powder but spread the remainder more evenly over the hands. Where I attend incidents and am likely to use powders for a protracted period I wear disposable gloves. For items required for examination at this police station I use a down-draft table that in theory should suck away airborne dust into a filter.

2. Risk of violence from criminal elements at scenes - people tend to relate to others in civilian clothes in a less confrontational way than to those who wear a uniform, presumably because those wearing a uniform project established authority. It appears that Lincolnshire scenes of crime staff are soon to be required to wear a uniform - for a corporate image or to make it appear that there are more police than there really are, you choose. Since we do not routinely double crew and in any case have insufficient or no training in self defence (it could be argued that this is not a core requirement of the job, which it is not) then I for one will feel more vulnerable at scenes.

From 1978 - 1993 I was a soldier in the Royal Army Ordnance Corps and, for my last six weeks in the Royal Logistic Corps (rebadged as part of the 'options for change' amalgamation and cost cutting measures). My trade was Ammunition Technician (AT), responsible for inspection, repair, modification and disposal of land service ammunition. From 1988 to 1990 I was based at Catterick detachment of 521 EOD Company RAOC, North Yorkshire. I investigated numerous incidents involving ammunition, some where people had been injured. Invariably such incidents were attributed to user error, ie people not using the ammunition or weapons as they were intended to be used.

In June 1989 three soldiers died of carbon monoxide poisoning on the depot demolition ground at CAD Kineton (now known as DM Kineton), Temple Herdewyke near Leamington Spa, Warwickshire. They were a Sergeant AT in charge, his assistant - a Lance Corporal AT and a sentry - a Private of the Royal Pioneer Corps. The sequence is that the AT in charge prepares the explosive demolition with the help of their assistant(s). Sentries ensure that nobody enters the demolition area. Once the demolition has taken place the senior AT returns to the site of the demolition to ensure that it has been a complete success and that the resultant pit is suitable and safe for subsequent blows. The Sgt did this but was overcome by carbon monoxide. After some minutes had passed and he did not return to the firing point his assistant went to look for him and was also overcome by carbon monoxide. After some time had passed and the assistant did not return to the firing point one of

the sentries went to look for the ATs and was also overcome by carbon monoxide. A remaining sentry finally raised the alarm. I was not involved in the subsequent investigation but can offer a possible reason as to why this tragedy happened. In 1983 the Sergeant and I were on a course as Corporals at the Army School of Ammunition, CAD Kineton. On the demolitions phase our instructors encouraged us to create and elongate tunnels in the hard clay soil with each successive blow. There was no mention of the likely production of carbon monoxide although that information was available to us but it was given no thought. I was more conscious that a tunnel roof might cave in while we were preparing the next blow, so kept mine short. We were able to create tunnels by careful positioning of the items to be destroyed and after a short amount of experience could deepen or elongate a pit as we desired. I just wonder whether my dead colleague was trying to do the same six years later. On that day the weather conditions may not have ensured the dispersal of carbon monoxide. I assume that the investigation reached whatever conclusion was appropriate.

With regard to H&S at incidents, Scenes of Crime Officers in this county are required to attend all work-related deaths, with a view to gathering evidence to assist police in determining whether there is a criminal case. This is normally as an adjunct to any HSE investigation. Incidents I have attended:

1. Elderly farm labourer clearing potatoes from the tipper bed of a trailer fitted with a hydraulically operated rear gate - head crushed by the gate being closed. The operator was found to be at fault and was fined. Holbeach area, approx 1998.
2. Worker at a timber merchant's crushed to death by a bale of wood falling on him. I do not know what the outcome was. Boston, approx 1996.
3. A roofer working on a fragile roof fell through the roof and died of head injuries. He was not wearing a safety harness. Sleaford area, approx 2000.
4. A farmer freeing an obstruction in his pea viner while the machine was still switched on was crushed to death after his leg caught in the machinery following his unblocking of the obstruction. Holbeach area, approx 1996.
5. A steeplejack died after falling from the scaffolding of a high agricultural building. I do not believe that he was wearing a safety harness. Spalding, approx 2003.
6. A worker was crushed to death by a heavy cart on a track at a concrete works. I believe he was crushed between the cart and a safety guard. Uffington near Stamford, approx 2000.
7. An electrician working on an office roof within a factory building fell and sustained fatal head injuries. It occurred because the rubber skids of his aluminium ladder had worn and the aluminium of the ladder was in direct contact with the concrete floor. When he stepped on the ladder to climb down from the roof, the base of the ladder slid on the concrete floor. Donington, approx 1999.

We are not called to injury-only incidents as a rule but one sticks out in my mind - a young couple almost died from carbon monoxide poisoning due to a faulty boiler. They had complained of flu like symptoms and headaches in preceding days and were found in bed unconscious by the young woman's father. Holbeach, approx 1999.

Case Study 2

I had a back injury at work just over 4 years ago, resulting in time off and slight loss of physical ability.

I work in Operating Theatres and for years the accepted practice of moving patients from bed to table was "all hands on deck". One day, using this ridiculous method, I suffered a severe muscle strain in my lower back, putting me off work for about two and a half weeks, on painkillers and leaving me with fairly constant aches. When I returned to my job I had a meeting with my Manager and a member of the Hospital Health & Safety team, who assured me that to prevent this happening again they were going to purchase some new equipment which would negate the need to stretch and lift patients. A DVD was used to show it in action. Wonderful.

However, 4 years later we are still waiting for it!

The NHS cares more about saving a penny than keeping its employees safe at work.

Case Study 3

I worked at 'Marjons' (University College Plymouth St Mark & St John) for 25 years. My job changed over the years as more and more students were enrolled. I began to be injured due to the workload and I asked personnel to come and see what I did. They said they knew and I was not expected to do heavy labour. I asked for a Health and Safety check by a qualified person but it never happened. But that is and was exactly what the job was, extremely heavy.

My left shoulder became excessively painful as well as my back, and the doctor arranged for me to see a specialist – who said I had a small tear in the rotator cuff – he thought – and a simple operation could put me right – I was put on the list – but it would be 5-6 months before I could be seen.

I had 11 accidents at work in 25 years.

Finally in Nov 2008 I was clearing away an Art lesson in an upstairs room, alone, as the other tech was busy elsewhere. I picked up a crate of metal rulers – the pain in my left shoulder was so severe and sudden that I dropped the crate. In great pain I left the room and reported to a senior lecturer who told me to go home and see my GP – it was hard driving when the left arm is not working properly.

My GP signed me off to wait for the op which was to be Feb 11 2009. After the surgery I came round and was told by the surgeon he would need to speak to me soon when I had recovered a bit. I had an appointment in March and returned to hospital – still using a sling as the pain had not gone away.

I was told that rather than a small stitch to repair the rotator cuff, the surgeon had had to remove the remains of the cuff – it was in pieces. The likelihood of my ever being able to use the arm 100% again was highly unlikely and he thought I would be lucky to get 40%. He said he had seldom seen such a severe injury.

I reported back to work the same day.

I was fast track retired as I could not do my job anymore and was permanently disabled 26% +. It now takes 2 men and a member of the office to do what I use to do.

All I needed was personnel to listen and get a qualified H&S person to properly assess the job I did. This never happened.

Case study 4

Some years ago an operative by the name of Ben was killed trying to seal what he thought was a leaking water main with a clamp it turned out to be an electricity main and Ben was up to his knees in water at the time and was killed suffering horrific burns. This was witnessed by several colleagues including one who had worked as his partner for ten years and Ben was like a son to him.

Ben had not been properly trained in the use of cable avoidance scanners (cat) and was not issued with one. Two of the witnesses have subsequently been forced to retire as a result of post traumatic stress syndrome and the third Ben's best mate still has an ongoing claim against the insurers. Dacorum Borough council was fined £70,000, just over half the Chief Executives' annual salary.

Unison welfare paid for the funeral and Thompsons were representing the other affected members. Shortly after the funeral Ben's widow received a letter from Dacorum Borough Council stating simply that Ben was no longer an employee of Dacorum Borough Council and that his employment had been terminated, highly insensitive to say the least. **So when you hear someone joke that “dying on the firms time is an instant dismissal offence!” you can tell them that they're not as far from the truth as they might think.**

Case Study 5

Last July I went to the Odeon cinema in Norwich and whilst walking to the ticket only area

I had got my tickets on-line - to avoid the sell out situation and i was meeting 2 friends at the cinema I turned the corner into the main atrium and fell.

I landed putting my arm out to catch my fall however it gave way and I had an awful pain which made me feel sick, and I could not move my arm. I looked to see how I had fallen and the cut out display stand for another film was there and I had fallen over this display stand which was sticking out behind the corner.

I guess in normal light conditions, without a mass of people, it wouldn't have been a problem and so no one had ever recognised or even identified this trip hazard. As a public building they should have carried out a structured and recorded building inspection!

The HSE investigated as I was off work for 8 weeks with a broken arm.

Case study 6

Will working with Asbestos be covered in this review as the effect of this industrial disease is not known for decades after contact. My Husband recently passed away from Mesothelioma.

Case Study 7

This is a case that has been going on for the last 6 months. Prior to this there was one member of staff who was being bullied and this stopped. The same bully then decided to pick on a temporary member of staff this year and this staff member has now walked out and has refused to come back. The sad thing about this is that she is not taking the case any further.

The same bully has now targeted 2 staff members and this is still going on. The manager of the department has not wanted to get involved and doesn't see it as part of his role. His manager is concerned and he has had a number of meetings with the staff members who are being bullied but until they put in a formal complaint he can't do anything expect keep an eye on the situation. HR are involved and they have been supportive but once again until the formal complaint goes in it appears that nothing can be done. Also I have spoken with HR and they are in the process of updating the bullying policy to include the use of Facebook and twitter and any other electronic system and the use of this to bully staff will not be allowed.

The bully was using the Facebook site to get at these two staff members but they have now removed their details from Facebook. The two staff members who are being bullied have got the Union involved but are scared to take it any further because they have been told something would happen to them outside work and if not their cars etc would be damaged.

At the moment the case is on hold because the two staff members are still reluctant to take case further and also there is going to be a change within the department and the might be moving.

The two staff members who are being bullied are seeing a counsellor at the moment and he has recommend that the bully is removed from the workplace and the line manager should be dismissed from his post.

Case Study 8

A multi-national company opened an office and factory in Coventry in 2000. They breached health & safety laws by bringing over machinery which did not meet European safety laws. (the machinery came in from South America).

One of my friends became entangled in the giant mixer and was unable to work again for many years. He sued the company and claimed damages. The HSE came into the workplace and a few changes were made to make the machinery more compliant and the company was operating again in no time. The accident took place in 2001.