



Hazards forum

The Hazards Forum Newsletter

Issue No. 62
Spring 2009

Hazards Forum Newsletter

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Views expressed are those of the authors, not necessarily of the Hazards Forum

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March 2009

HAZARDS FORUM AGM

10th March 2009

An account of the Annual General Meeting is scheduled to appear in the next Newsletter (No. 63) because of the proximity of the publication date for this Spring issue.

INTERPRETATION AND ENFORCEMENT OF HEALTH AND SAFETY LEGISLATION – HAVE WE GOT IT RIGHT?

This Hazards Forum evening event was held in the Great Hall at King's College, The Strand, London on **Wednesday, 21st January 2009**. The meeting was co-sponsored by the Society of Construction Law. **Mr. Justice Ramsey, Judge in Charge of the Technology and Construction Court**, who chaired the event welcomed everyone and introduced the speakers.

The first speaker was **Michael Appleby of Housemans**, Solicitors who said he started his career in claims for injury cases. He began by quoting Francis Bacon (1620):

“The human mind is prone to suppose the existence of more order and regularity in the world than it finds”

The assumption, particularly from the public and the media in relation to accidents/disasters is that these bad outcomes are due to bad actions and bad health and safety. Very often this is not the case.

Mr Justice Slade (as he was then) in the prosecution of train driver Wembridge for manslaughter for passing a stop signal which led to the Eastbourne train crash of 1958 observed that the grossest negligence could cause no damage at all, and a slight degree of negligence could cause the gravest damage:

“It would not be right to visit the consequences of this misfortune upon the person who made a mistake, if that is the correct word, merely because it happened to lead to those deaths”

However the bad outcome of an incident, I believe, often places huge pressures upon the authorities for some kind of prosecution. Such cases generally do not make for good law.

Compare Hatfield train derailment (2000 – broken rail – 4 deaths) and Southall East train derailment (2002 – bolts in a fishplate which holds the rail in place at a set of points falling out – no deaths): Fines £7.5m and £3.5m against £300,000 and £200,000. An engineer expressed the view to me that the corporate failings in both cases were similar. The question he then posed was ‘so why are the fines so different?’ In my experience the criminal arena has difficulty dealing with such prosecutions. It is generally accepted that there were many causes of the Hatfield derailment but the prosecution concentrated on just one element – maintenance.

Example - of Watford Train Crash where the case just concentrated on driver passing a red signal light. There had been 5 previous cases of passing red lights but it was difficult to find out what actually happened. The media wanted its pound of flesh. To my mind to have a just prosecution there must be a proper understanding of the incident and a proper enquiry into that incident.

In my experience it is an unfortunate by product of the reverse burden of proof is that an adequate enquiry into an incident does not always take place.

Risk and Hazard

Hazard and Risk were defined in a letter to the Times from Dr MJ Pemberton 2nd February 2006.

The failure to distinguish between ‘risk’ and ‘hazard’ is the reason why so many foolish decisions are made in the name of health and safety. The hazard is a circumstance with the potential to cause harm, the risk is the likelihood that this potential will be realised.

But in *R v Porter* CA May 2008 - following the tragic death of a child at school the Court of Appeal distinguished between real risk, as opposed to “fanciful or hypothetical risk”. There has recently been useful guidance from the courts.

R v Chargot and others (UKHL 73) December 2008, approved *Porter* saying the relevant risk in HSWA was:

“a material risk to health and safety, which any reasonable person would appreciate and take steps to guard against”

However there is still in my view a need for judicial guidance on what exactly risk is, if only to endorse the definition in the ACoP to the MHSWR 1999. Former PM Tony Blair in a speech in 2005 said we are in danger of having a disproportionate attitude to the risks we should expect to run as a normal part of life. Judith Hackitt in an interview on new HSE's strategy in February 2009 *Health and Safety at Work Magazine* re competent advice from legal advisers:

We need people out there giving advice that is proportionate, isn't over the top any more than it is inaccurate

There is a danger of considering safety just from the point of process - people become obsessed with the process and forget to think about the risk.

Section 3 HSWA was originally added to the Act as a residual category but have we gone too far? Robens is about industrial accidents. Para 289 Robens Proposed authority (HSE) *should be able to deal with any matter that falls naturally within its technical competence, whether or not employed persons are involved.*

Prosecution of hospitals by HSE, e.g. *R v NHS Southampton Trust*: The controversial prosecution of the Met Police (not by HSE) in relation to the Stockwell shooting. 19 failures listed. Compare the concept of risk in these failures – Hazard or real risk?

Reasonably Practicable

Edwards v National Coal Board where it was stated:

“'Reasonably practicable' is a narrower term than 'physically possible' and seems to me to imply that 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 Defendants discharge the onus on them”

Case concerned the Coal Mines Act 1911. It was a civil case – a claim for compensation.

Select Committee on Economic Affairs (5th Report of Session 2005-06) entitled *Government Policy on the Management of Risk* the House of Lords stated at paragraph 101:

“In our view, the use of ill-defined and ambiguous terms in risk-management and regulatory documents is generally unhelpful.

Work and Pensions Committee in its 3rd Report of Session 2007-08 entitled *“The role of the Health and Safety Commission and the Health and Safety Executive in regulating workplace health and safety”* stated:

“We are concerned that the test of “reasonable practicability” introduces a lack of clarity that can increase the burden on employers in meeting their health and safety obligations. We recommend that the Law Commission reviews the test of “reasonable practicability” and how it applies to the Health and Safety at Work Act 1974”

Government has rejected the recommendation. I believe the term should be revisited.

Leadership

HSE's publication INDG 417 refers to recent legislation *R v P Ltd and G*. It says:

“...directors cannot avoid a charge of neglect under section 37 by arranging their organisation's business so as to leave them ignorant of circumstances which would trigger their obligation to address health and safety breaches.”

In legal argument CA said:

“If there is a proper system set up for health and safety that will usually be sufficient for [a director] to say “I have done my duty. I have set up that system”, in the absence of material to make it plain to him that something was actually wrong with it.”

The guidance does emphasise the importance of safety systems in its checklist at the back, but makes no reference to what CA said in this regard.

Eventually the prosecution offered no evidence against G. But note in the prosecution it put its case as follows:

“...our contention is the buck must stop with those in charge, and that is why I assert that it is relevant to consider that [the defendant] was not simply a director but a managing director, and I was not saying that in some way the law views them differently, but factually it must be relevant, because a managing director must have, we submit, greater responsibility than a director – his duty is to manage.”

Is this an encouragement to leadership?

Sanctions

In a consultation the Sentencing Advisory Panel in respect of the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA) has recommended that fines be based on turn over. For CMCHA this should range between 2.5% and 10% of turnover and for breaches of HSWA between 1.5% and 7.5%.

Do large fines improve safety?

A graph on page 9 of *Health and safety statistics 2007/2008* shows that the number of annual workplace deaths reached a plateau in the late 1990s, after years of steady decline. Large fines started at the end of the 1990s following the *Howe* ruling (the leading authority on sentencing) eg *R v GWT* £1.5m 1999. The statistical evidence does not seem to support the argument.

The Health and Safety (Offences) Act 2008 came into effect on 16th January 2009. The Act extends the £20,000 maximum fine in the Magistrates' Court to a wider range of offences and provides the courts with the power to imprison for most health and safety offences. This means that individuals convicted in the Crown Court of breaching section 7 or section 37 HSWA could be sentenced to a term of imprisonment of up to two years.

Prison will be reserved for those defendants that are “especially blameworthy”. What does that mean?

Interpretation and Enforcement – have we got it right?

Interpretation

As detailed earlier there are areas where clarification is needed. In my view these relate to exactly how we define ‘risk’ and what we really mean by ‘reasonably practicable’. This I think is urgent if we are to stop businesses being risk adverse.

Prosecutions

Judith Hackitt

“...we don't set targets, and we won't set targets for numbers of prosecutions”

The perception of some is that it feels as if there are targets. It is also important that authorities are not perceived to simply be responding to public/media pressure.

I have said that it is important to understand the incident. In my experience prosecutors can sometimes be left wanting in this area. Even if the company is going to plead guilty it is important that the company is sentenced on a correct understanding of the accident.

I believe with fines increasing and the potential of prison we are likely to see more contested trials and even where guilt is admitted contested hearings to determine the level of guilt.

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Closing Thought

In 1993, at the time of the last recession, Michael Baram, a Boston law professor, observed:

“[A]s a society progresses, it demands a higher degree of safety. Thus, safety is a target moving continuously towards zero risk, except for interruptions during times of economic distress or high unemployment.”

Will the credit crunch change our view on risk?

The second speaker was **Sir Bill Callaghan, the former chairman of the HSC**. He referred to the work of Lord Robens as a work of great wisdom. There were six key issues which were raging in the past and were still important now; they were faced by every regulator and a balance had to be struck.

1. The balance between enforcement and advice
2. The balance between prosecution and other forms of enforcement
3. The balance between proactive and reactive work
4. The balance between goal setting and prescription
5. The balance between culpability and harm in deciding on sentencing
6. The balance between the several purposes of punishment

The balance between enforcement and advice

Bill Callaghan argued that the paper for the Event should have given more prominence to HSE's work on advice and guidance; these were built into the statutory purposes of HSE and there was no evidence to suggest that HSE had shifted away from advice giving; any discussion on enforcement had to take this work into account.

The balance between prosecution and other forms of enforcement

Bill Callaghan referred to the introduction of Improvement and Prohibition Notices as one of the great reforms of the 1974 Health and Safety at Work etc Act. HSE could claim to be one of the first modern regulators and much of what was recommended in the McCrory report on penalties, HSE was doing already. In 2007/08 the HSE issued 7740 notices and only 1137 prosecutions. The paper should have recognised the role of Improvement Notices (INs) and Prohibition Notices (PNs) as part of HSE's proportionate approach.

The balance between proactive and reactive work

Both proactive work (announced and unannounced inspections) and reactive work (responding to complaints; incident investigation) could involve enforcement. The balance between the two activities varies. It was pertinent to note that about only 6% of incidents were investigated. This low proportion had been

criticised, but a small increase in percentage points would lead to a huge drop in proactive work. Bill Callaghan argued that his view was to favour proactive work and evidenced activities such as the construction blitzes.

Bill Callaghan drew attention to the fact that 130,000 RIDDOR incidents led to only 1,400 prosecutions and 14,000 notices. In contrast to the argument of the paper given to delegates and the previous speaker that HSE was too tough, many might draw the conclusion that HSE was not tough enough.

Bill Callaghan drew attention to the importance of the Enforcement Policy statement and the fact that there was no evidence to suggest an increase in defended prosecutions.

The balance between goal setting and prescription

Bill Callaghan argued the importance of "So far as is reasonably practicable" (SFAIRP) in the British health and safety system. There were calls from both employers and unions to define SFAIRP but that would be a great mistake. It would lead to rigidities in the system and business and the regulator would find it difficult to deal with technological change. The European Union had been critical too and the UK's victory in the European Court against infraction proceedings was very welcome.

Bill Callaghan drew attention to the general duties in the Act, regulations, Approved Codes of Practice (ACoPs), and guidance. There needed to be a robust dialogue between the regulator and the regulated so that there is a common understanding of business needs, but HSE was an independent regulator and did not have to agree with everything business said.

Alluding to the financial crisis, Bill Callaghan argued that the value of having a tough independent regulator was now more readily recognised.

The balance between culpability and harm

This was a difficult issue for anyone involved in the criminal justice system; both factors had to be considered. It was wrong to imply that HSE prosecutions were motivated by vengeance. However, the public would find it strange if deaths at work were not followed by regulatory action. Nevertheless although every death at work was investigated, not every death led to a prosecution, for one reason or other: it would not be in the public interest, or there was insufficient evidence to bring a case.

But HSE did not just act on harm: the HSE prosecution of BP Grangemouth was relevant. A series of near misses had not led to harm but could have had catastrophic consequences.

The balance between the several purposes of punishment

Bill Callaghan drew attention to the several purposes of sentencing, e.g., deterrents, protection of the public, rehabilitation, punishment, prevention. He argued that until recently punishments for Health and Safety offences had little deterrent effect. In 2007/08 the average fine following an HSE prosecution was just under £12,000, and excluding the limited number of fines above £100,000 was just over £7,800. This was a low figure.

The new Offences and Penalties Act had been a long time a coming, its provisions having first been mooted in 1999.

Conclusion

Bill Callaghan concluded that HSE had to strike a balance. No company liked being prosecuted, but whether out of altruism or self interest, there was no demand from British business as a whole for HSE to enforce less.

The Enforcement Policy statement had been independently reviewed and was found to be fit for purpose.

Bill Callaghan then drew attention to changing public duties to health and safety and a hardening of attitudes against corporations and individual directors. Many factors lay behind this including the four high profile train crashes at Southall, Paddington, Hatfield and Potters Bar, the failure of manslaughter charges under the previous law, the delay in introducing the new law of corporate manslaughter, and all of this against a background of growing corporate power and influence. Most people, following a serious incident, would highlight prevention of recurrence as a priority, but the above factors were leading to increasing calls for retribution, particularly when companies did not apologise.

Finally, Bill Callaghan discussed Section 3 of the Act and emphasised that this was governed by "reasonable practicability", though there was less common ground between the regulator and the regulated on what was practicable. Events such as Flixborough and Buncefield showed the importance of Section 3. He emphasised that the prosecution of the Metropolitan Police following the Stockwell shooting was not taken by HSE.

Mr. Justice Ramsey then called for questions and comments. There was a general discussion on whether sentencing had a place in improving safety. Some felt that it restricted sharing of information and was inappropriate in cases where there was a slight slip-up. The blame culture was questioned and should be avoided. The meeting was co-sponsored by the Society of Construction Law. The chairman thanked the speakers for their contributions and also those who contributed to the discussion session. Following this, John Barber made concluded remarks and closed the meeting.

THE WORK OF IOSH

Founded in 1945, the Institution of Occupational Safety and Health (IOSH) has around 34,000 individual members, including over 13,000 Chartered Safety and Health Practitioners. IOSH is Europe's largest occupational safety and health (OSH) professional body and has strong OSH links worldwide, with members in over 80 other countries.

Incorporated by Royal Charter, a registered charity and an international NGO recognised by the ILO, IOSH is the guardian of OSH standards of competence in the UK and provider of professional development and awareness training courses. The Institution steers the profession, maintaining standards and providing impartial, authoritative, free guidance on OSH issues. It is regularly consulted by government departments and other bodies on OSH issues and is founder member of UK, European and International professional body networks, acting as secretariat to the last two organisations. The Institution also has a research and development fund, which is focused on helping establish and develop the evidence-base for OSH policy and practice and on closing knowledge gaps in this area. Additionally, the Institution has an active campaigns and lobbying programme and is currently running four campaigns: 'Putting young workers first'; 'Get the best'; 'Stop taking the myth'; and 'Back to health, back to work'.

In terms of the structure, IOSH has 29 Branches including in the Caribbean, Hong Kong, Middle East and the Republic of Ireland. It also has 17 special interest groups covering a wide variety of employment sectors and topic areas: aviation and aerospace; communications and media; construction; consultancy; education;

environment; fire risk management; food and drink; hazardous industries; healthcare; international; offshore; public services; railways; retail and distribution; rural industries; and safety sciences. The hazardous industries group currently has nearly 900 members – membership is open to all those with an interest in, or connection to, the management of risk in high hazard industries e.g. chemical process, power generation, gas and electrical distribution, petro-chemical and nuclear installations. IOSH members work at a variety of strategic and operational levels across all employment sectors and our vision is: “A world of work which is safe, healthy and sustainable”. For more information about IOSH and its work, please see www.iosh.co.uk.

Enhanced role for health and safety professionals

Within occupational safety and health (OSH), it is generally accepted that while safety concerns remain, the main challenges for the future are in the health arena. Last year in the UK, 2.1 million people suffered an illness they believe was caused or made worse by their work, and an estimated 28 million working days were lost as a result of work-related ill health.

Back in 2006, IOSH responded to the government’s Green Paper on welfare reform (*A new deal for welfare: empowering people to work*), highlighting the need for a ‘sea change’ in national occupational health provision and leadership, more ‘worker-friendly workplaces’, and an enhanced role for OSH practitioners. IOSH sees practitioners helping form the ‘critical mass’ needed to ensure better prevention and early intervention, and where illness does occur, ‘bridging the gap’ between absence and a safe return to work, as part of a co-ordinated multidisciplinary approach.

The primary focus of OSH practitioners has always been on preventing work-related injury and illness and that will remain the case. However, with an ageing population and a drive to create a more inclusive and diverse workforce, in which people aren’t simply ‘written-off’ because they’re not 100% fit, IOSH has identified an additional part that OSH practitioners can play, helping to support vulnerable workers remain in, or return to, work safely. To maximise the impact and efficacy of qualified occupational health professionals, and to prevent conditions becoming chronic, IOSH thinks better use should be made of OSH practitioners. There are relatively large numbers across the country and who already have a

degree of occupational health knowledge; are well-established in the workplace; and are able to provide a support function in terms of noticing when things may be going wrong, raising awareness, communicating policies and services, and promoting the health and wellbeing message.

The ‘gap’ in the current support system is well recognised and in addition to providing improved access to high quality occupational health services, IOSH believes Britain needs to find a better way of harnessing the entire national support resource. This would involve a minimal amount of extra training for around 10,000 OSH practitioners, who could also, for example, act as workplace advocates; play a role in educating managers; and help ensure earlier interventions and referrals. Many issues that prevent a return to work are not clinical, but organisational, and OSH practitioners are ideally placed to play a vital role in helping employers and workers address these.

In her recent ground-breaking review (*Working for a healthier tomorrow*), Britain’s first-ever National Director for Health and Work, Dame Carol Black, highlighted the incalculable human cost of worklessness to this and future generations and also, the burgeoning financial cost to the economy of working-age ill-health (an estimated £100 billion each year). She reports on the “...historical failure of the healthcare and employment support services to address the needs of the working age population in Britain” and the hope that her review “...will lay the foundations for urgent and comprehensive reform”. Her recommendations for improving the system included an enhanced role for OSH professionals in promoting the benefits of employer investment in health and wellbeing of the workforce.

The government has responded positively to Dame Carol’s recommendations and has announced a wide range of programmes and pilots, which IOSH believes could be potentially far-reaching and herald a new approach to the management of health and wellbeing in this country. Its *Improving health and work: changing lives* report also highlighted a joint-funded project between IOSH and the DWP, piloting a new training programme to help OSH practitioners further their understanding of health and wellbeing at work. Building on their core competence training and experience, IOSH believes the focussed two-day training course will equip them with the knowledge and skills to enable them to play a more active role in the

management and promotion of health in their workplaces. Ideally positioned and sufficient in number, once trained – they could help make a real difference. IOSH is also pleased to see the report making the point that there is no clear boundary between health- and safety-related issues, which are intrinsically linked.

Recent IOSH activity on occupational health

The IOSH research database for OSH

This database aims to enable IOSH members and non-members to access information about OSH research in UK and EU and beyond, providing a focused and dedicated resource to assist those with an interest in OSH research with their work, studies and continuing professional development (CPD). The OSH research database is being constantly developed and seeks to provide comprehensive information on academic, commercial and public sector OSH research in the UK and Europe. Data on the UK academic sector is now available on the IOSH website at www.oshresearch.co.uk/

Currently there are around 200 research projects listed on the database and about a quarter of these are examining Occupational Health topics. This includes projects looking at the EU priorities areas of psycho-social issues and musculoskeletal disorders (MSDs) as well as projects on specific aspects of occupational health such as dermatitis, tobacco smoke exposure, toxicology and the statistical measurement of occupational health. The database also holds information on projects that are looking at aspects of the labour market including studies focussing on vulnerable groups such as migrant workers and older workers.

The IOSH Occupational Health Toolkit

This is a freely available online resource (at www.oh toolkit.co.uk/), bringing together information, guidance, factsheets, case studies, training materials, presentations and more, to help OSH practitioners and others tackle occupational health problems. The toolkit deals with topics such as stress, musculoskeletal disorders, inhalation hazards and skin disorders, and covers the whole process – from learning the background to a health issue, through identifying and dealing with early indications of problems, right to supporting people back to work if they have been off ill. The Occupational Health Toolkit also gives guidance for OSH practitioners on working with colleagues in occupational health specialisms.

To further help OSH practitioners and others, IOSH has also developed a rehabilitation guide “**A healthy return – a good practice guide to rehabilitation**”, providing a grounding in rehabilitation, return to work and absence management issues. It is freely available, along with all our other guides, from the IOSH website at www.iosh.co.uk/techguide and contains:

- an overview of rehabilitation
- a ‘work adjustment assessment’ to help assess the workplace needs of employees with impairments or medical conditions
- case studies that demonstrate rehabilitation in practice
- sources of further information, reading and training

IOSH is also producing a ‘**Promoting health and wellbeing at work**’ guide, to promote wellbeing as a holistic, proactive approach to managing health issues at work, taking a multidisciplinary approach to improving employee health, wellbeing and work performance and reduce sickness absence through:

- identifying and addressing the causes of workplace ill health
- addressing the impact of health on the capacity to work (supporting employees with disabilities and health conditions, rehabilitation)
- promoting a healthier lifestyle and so impact on the general health of the workforce

The new guide will outline the main health and wellbeing issues; the key drivers for action; why OSH professionals should get involved; the ‘Investors in People’ framework for wellbeing; implementing a wellbeing strategy; and resources, tools and case studies.

Research projects

The IOSH research fund has commissioned 15 research projects since it was established in 2004, including several on occupational health issues:

- ‘The relationship between work / working and improved health, safety and wellbeing’, examining what characteristics of jobs are ‘good’ for health and the relative importance, effect sizes and optimum combinations of these.
- ‘The effect of work-related violence on employee health and wellbeing’, seeking to further understand the causal relationships

between work-related violent events and wellbeing outcomes for employees and interventions to limit the risks.

- 'An epidemiological study of occupational voice demands and their impact on the call-centre industry', which will investigate vocal communication demands for centre workers, evaluate vocal health, awareness and performance, and aim to identify key risks and training needs.
- 'Reliable industrial measurement of body temperature', this aims to determine a predictive relationship between infra-red and intra-gastric temperature for core-body temperature measurement, so that reliable and practical heat strain measurement can be undertaken in hot working environments – key to worker health and safety in many industries.

We are also looking to fund research analysis into the effects of shift work on health (based on a French longitudinal study collecting ageing, health and work data), with the main aims of diagnosing long-term effects of shift work on health issues and examining the implications for health and safety management and prevention, especially job design and work organisation. The researchers intend that by examining the root causes of the cognitive deficits associated with long-term exposure to shift work, they may be able to throw light on the underlying causes of safety problems related to shift work (e.g. Three-Mile Island, Bhopal, Challenger, Chernobyl and Exxon Valdez) and identify appropriate techniques for minimising them.

IOSH provides 'summary reports' of research it commissions outlining the main findings, and these are available to freely download from the IOSH website (www.iosh.co.uk/researchsummaries). There are currently two available: 'The impact of health and safety management – on organisations and their staff' and 'The impact of expert health and safety advice – on company performance' and more will follow once further studies are completed.

Richard Jones
IOSH Policy and Technical Director

TALKING TIMBERS

Clanging bells, warning sirens and chirping canaries have long been used to warn of impending danger in confined spaces. But *talking timbers*? So were named a 19th century expedient used in the gold mines of Ballarat in Australia.

The timbers were narrow tree trunks cut and wedged to fit vertically between the ground and the roof of the quartz seam being worked. They were sensitive enough to detect any movement in the rocks overhead so that the resulting audible creaking of the wood gave warning to the miners of a possible roof fall. They were fitted as a warning system in case the pillars of quartz left to support the roof were insufficient.

These primitive seismographs were introduced to the Australian goldfields by migrating tin miners from Cornwall as a second safeguard against roof falls.

John Bond

NATURAL HAZARDS UPDATE

Natural Hazards is a service of NASA's Earth Observatory.

CROPS AND DROUGHT

Ten million people could face hunger in Kenya after a poor harvest.

DUST, SMOKE, AND HAZE

Haze hovered over eastern China in mid-January 2009.

Dust plumes blew off the coast of Saudi Arabia and over the Red Sea in mid-January 2009.

A dust plume several hundred kilometers long blew off the north coast of Egypt and over the Mediterranean Sea in late January 2009.

Thick haze collected south of the Himalaya in early December 2008, continuing a weeks-long pattern.

Dust plumes blew off the Libyan coast in early January 2009.

FIRES

Agricultural fires are widespread across Ghana in the dry season.

FLOODS

Drenching wet-season rains led to extensive flooding in Northern Territory and Queensland, Australia, in early January 2009.

Crops, roads, and homes were all swamped when rivers burst their banks in southern Sumatra in late December 2008.

SEVERE STORMS

Madagascar was plagued by two tropical cyclones in mid-January 2009. Cyclone Eric brushed the northeast coast on January 19, killing at least one person and leaving nearly a thousand homeless, according to news reports.

VOLCANOES AND EARTHQUAKES

Chile's Chaiten Volcano remained active in early 2009, releasing plumes of ash and/or steam.

In the early morning hours of January 4, 2009, a pair of powerful earthquakes rattled Papua, Indonesia.

A 6.1 magnitude earthquake in Costa Rica shook the country on January 8, 2009. The event triggered landslides which killed at least 20 people.

NOTES BY THE EDITOR

Some new developments have been noted on the OECD and HSE Web Sites.

OECD WEB SITE

http://www.oecd.org/department/0,3355,en_2649_34369_1_1_1_1_1,00.html

Chemical Accidents

The OECD Programme on Chemical Accidents addresses a subject that concerns everyone who uses or handles hazardous chemicals, works in a chemical plant, or lives near one. This programme helps public authorities, industry, labour and other interested parties prevent chemical accidents and respond appropriately if one occurs.

What's New

Guidance on Developing Safety Performance Indicators - for Public Authorities and Communities/Public - for Industry.

These have now been published. 09 Sep 2008

Report of the Workshop on Human Factors in Chemical Accidents and Incidents

This has now been published. 28 May 2008

HSE WEB SITE

The Paper No: HSE/09/24 on information sharing is now available on the HSE web site at:
<<http://www.hse.gov.uk/aboutus/meetings/seboard/2009/250209/agenda.htm>>

NEWS OF THE NEW HAZARDS FORUM WEBSITE - from the Secretary

The website continues to be updated and is thus worth visiting from time to time. As well seeing developments in the events programme, a visit to the sponsor's page at http://www.hazardsforum.org.uk/events/events_sponsors.asp will show current and recent supporters of Hazards Forums events together with a link to their home page as a gateway for seeking further information about them and areas of business that may be of particular interest.

Brian Neale

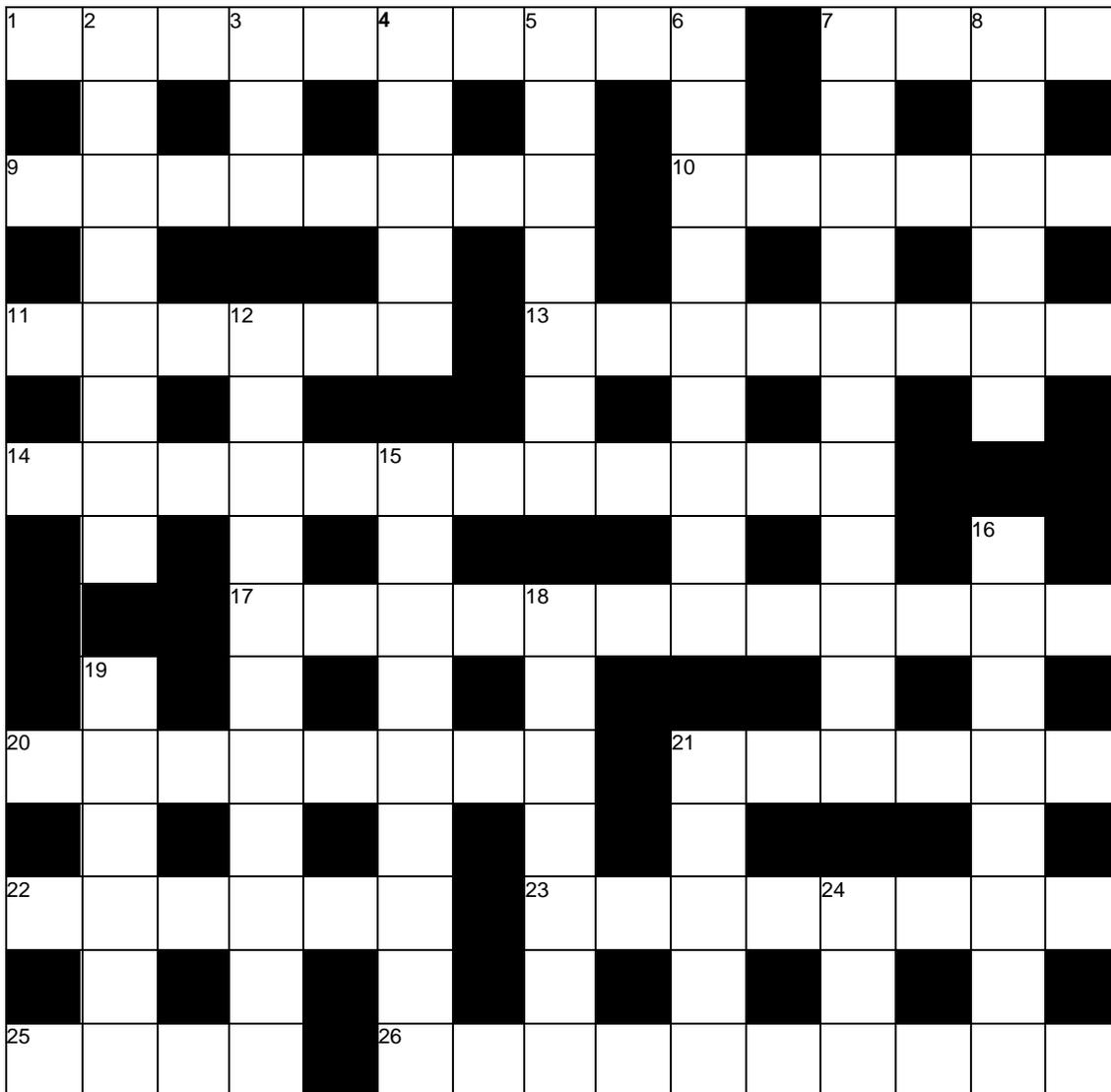
The Adventures of the Safety Inspector

Hell's Fire

The Safety Inspector's next aim
Was to find out why Hell was aflame
Did its management make
A disastrous mistake?
Or was auto-ignition to blame?

Our Safety Inspector was quick
To uncover Prometheus's trick
He proved that Hell's pyre
Was made from the fire
That was stolen, then flogged to Old Nick.

HAZARD FORUM CROSSWORD PUZZLE No. 3 by Miss M. Bond



ACROSS

1. Noah's Ark was. (10)
7. Leakage caused by blowing one. (4)
9. Having an inferiority complex is pretty unsafe. (8)
10. Nettles suggest how not to behave in dicey situations. (6)
11. Scholarly inspectors here. (6)
13. American pudding in good order. (5-3)
14. Oddly enough, a cruel tumble is always someone else's fault. (5,7)
17. Amends made to a successful participant in 14. (12)
20. A mobile with mobility. (3, 5)
21. Even if spark proof, pliers can produce other dangers. (6)
22. A just culture, say, needs a tweak (6)
23. Some boils and spots are common near drilling rigs. (3, 5)
25. Hole for furniture. (4)
26. A noted return to the hills finds explosive gadgets. (10)

DOWN

2. Country starts falling sick - refuse to go there. (8)
3. Metallic raw material of Scandinavian coinage. (3)
4. ...or an Italian river on German and British coinage. (5)
5. On the whole protective clothing needs more than one. (7)
6. Dismiss favourable ads for hose hydrants. (4-5)
7. Carbon monoxide alarm disturbed the wrong red cottages. (3, 8)
8. They say Philip can provide a stimulus.(6)
12. After a while tablet is quite out of this world. (4, 7)
15. Bach, for instance, recycled vegetable matter without first treating it. (9)
16. Using a twenty while driving in Switzerland may turn you into one! (8)
18. Engineering component helping you watch lightning discharge. (3-4)
19. Many a wild danger unearthed here. (6)
21. Part of the propyl one uses for carrying power. (5)
24. Backward at sea. (3)

Solution to Crossword Puzzle No. 2

Across

1. Escape
5. Leakages
9. Alarming
10. Relief
11. Incident
12. Spills
13. Hot-wired.
15. Fret.
17. Skit
19. Sergeant
20. Select.
21. Tail-lamp
22. Avenue.
23. Inert gas.
24. Database.
25. Shoddy

Down

2. Silencer
3. Airtight.
4. Epicentre.
5. Lightning strike.
6. Kneepad.
7. Gridlock.
8. Safe seat
14. Examiners.
15. First aid.
16. Effluent.
17. Stiletto.
18. Isambard
19. Succumb

DIARY or CALENDAR OF EVENTS

Please check the Hazards Forum website at www.hazardsforum.org.uk under the Events section for more information and to see any updates in the calendar such as additional events or perhaps amendments to the Events shown below which being proposed and developed. Please note that attendance is by invitation.

Date	Event	Venue	Contact/further information
2009			
MAY 21	HF Supported event: Software technology - a one-day seminar to examine the latest developments	Copthorne Hotel, The Close, Quayside, Newcastle upon Tyne NE1 3RT	Book via: www.imeche.org/events/s1432 Also; Tel +44 (0)20 7222 7899 or see www.imeche.org
JUNE 16	HF Evening Event: Joint meeting with Ergonomic Society - <i>How ergonomics improves patient safety</i>	Institution of Civil Engineers, One Great George Street, Westminster, London, SW1P 3AA	Adam at hazards.forum@ice.org.uk
SEPTEMBER 22	HF Evening Event: Joint meeting – First of Three in <i>Energy Series</i>	Central London	Adam at hazards.forum@ice.org.uk
NOVEMBER 24	HF Evening Event: Second of Three in <i>Energy Series</i>	Central London	Adam at hazards.forum@ice.org.uk
2010			
MARCH 16	HF Evening Event: Third of Three in <i>Energy Series</i>	Central London	Adam at hazards.forum@ice.org.uk
16	Also, advance notice for the AGM		
