

HSE Investigation



What do I hope to discuss today?

- How HSE investigates
 - Interaction with other Regulators
 - What works well
 - Investigation Outcome
-
- A little inflatable inspection information to close

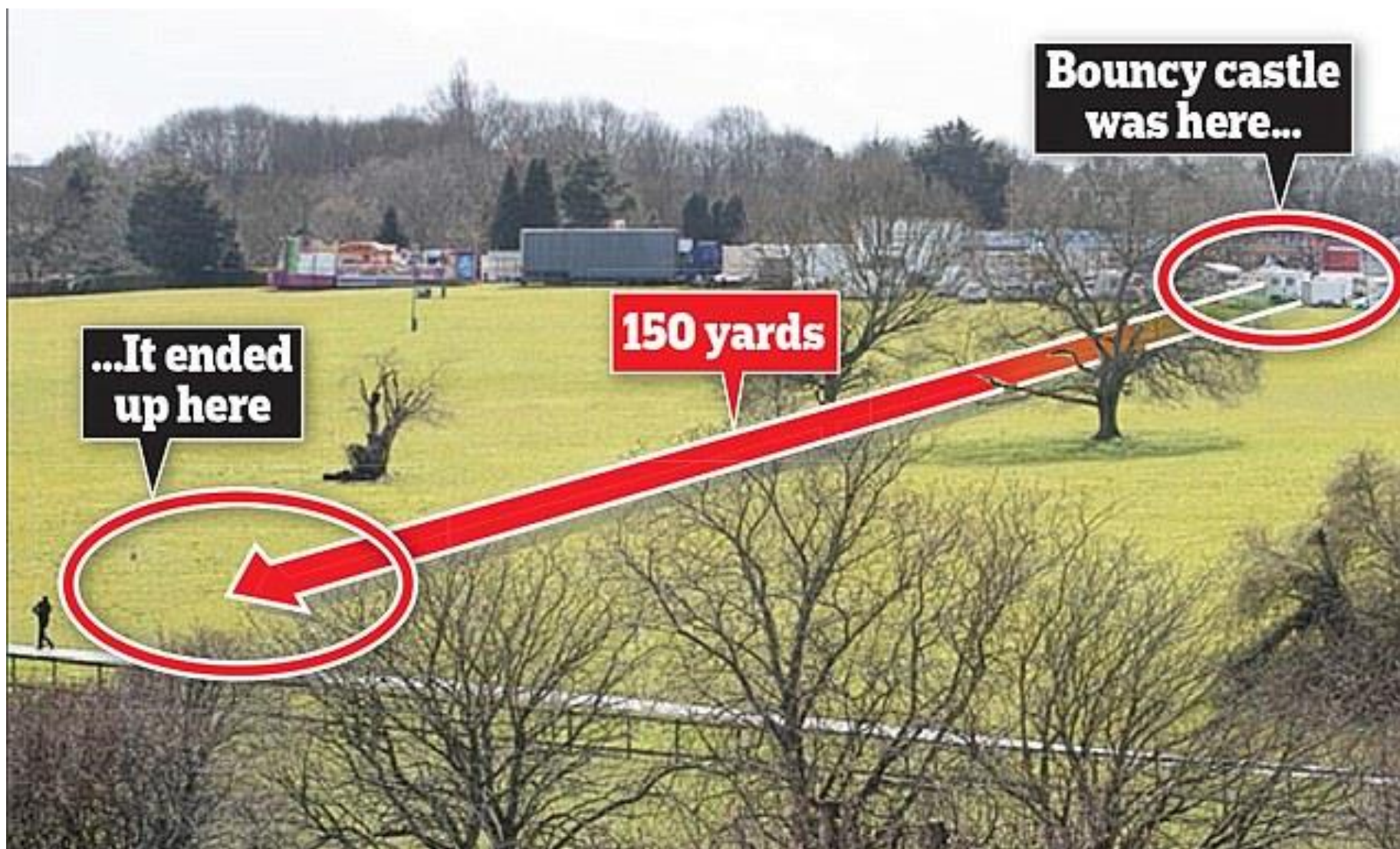
Harlow Fatality – March 2016

“Witnesses tell of horror as they watched bouncy castle blow away to 'tree-top height' in a gust of wind with seven-year-old girl inside before killing her when it crashed” – Mail online

Summer Grant, died from multiple injuries after a strong gust of wind swept the inflatable across a park in Harlow, Essex, on March 26 2016.

Shelby Thurston, 25, and husband William Thurston, 28, who were responsible for the bouncy castle were jointly charged with gross negligence manslaughter and found guilty at court.

The Scene



First Responders



Work Related Death Protocol



Work-related Deaths:
A protocol for liaison
 (England and Wales)

<https://www.hse.gov.uk/enforce/wrdp/>

Signatories

	Commander Dean Hayden Metropolitan Police Service National Police Chiefs' Council	
	Paul Crowther Chief Constable British Transport Police	
	Paul Hancock President Chief Fire Officers Association	
	Alison Saunders Director of Public Prosecutions Crown Prosecution Service	
	David Behan Chief Executive The Care Quality Commission	
	Imelda Richardson Chief Executive Care and Social Services Inspectorate Wales	
	Richard Judge Chief Executive Health and Safety Executive	
	Kate Chamberlain Chief Executive Healthcare Inspectorate Wales	
	Nick Worth Regulatory Services Champion The Local Government Association	
	Alan Massey Chief Executive Maritime and Coastguard Agency	
	John Wilkinson Director MHRA Medical Devices Division	
	Richard Savage Chief Inspector Office for Nuclear Regulation	
	Richard Price Chief Executive Office of Rail and Road	
	Neil Moore Spokesperson for Regeneration, Economic Development and Regulatory Services The Welsh Local Government Association	

Investigating the Incident

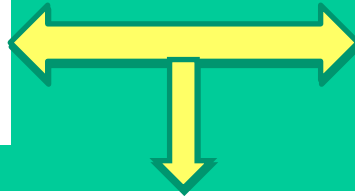


Early Activities

On- Site Actions

**First on-site:
First
Responders**

**HSE:
Inspector(s)
SG?**



Establish good communication:

- **Discuss WDRP**
- **SOCA – they can take (most) of your photos**
- **Assist police to gather documents and items of use to them and you (saves the big box of everything being passed over in the future)**
- **Reduces mixed messages to people of interest**
- **Identifies areas of interest and possible outside assistance required**
- **Assist preparing joint question sets**

Off-Site Considerations

- **Comms requirements,**
- **Admin Support – previous duty holder history, contact manufacturer\importer etc.**
- **Policy\Portfolio Holder support**
- **What (HSE)SG resource is required?**
- **Trade Association information and contact**
- **Are external specialists required?**

Investigating the Incident (2)

Work Related Death Protocol Decision

POLICE PRIMACY:

GNM

Police lead and we continue to support and direct:

- Assist in question sets
- Sit in on witness statements
- Sit in on Pace
- Provide the knowledge and detail for the prosecution from the evidence gathered
- Joint meetings with CPS
- Involved in Coroner updates



What Does All This Early Work Gain Us, If Police Hand Over Primacy?



Answer:

A lot of hard work already done and so saves time later down the line.

**YOU CAN
WITH**



What was discovered

Issues –

- The correct number of stakes for the inflatable were never found on site.
- Wind speeds\gusting was known to be above the safe level for operating inflatables
- Risk assessment issues – may have been prepared post event

Investigation Outcomes



Crown Court – Not Guilty
Pleas entered.

Jury Trial – both found guilty
of Gross Negligent
Manslaughter and a further
charge under HSWA Section
3(2)

Sentenced – GNM 3 years
each and a concurrent further
12 month sentence for
HSWA offence

Initial Enforcement Expectations

- Missing or damaged anchor points (PN)
- Bungee ropes or other inappropriate ropes used for securing anchor points (PN)
- Anchors points (high or low) not being used (inside or outside) or not used inline with the requirements of the OM (PN)
- Uneven distribution of anchor points i.e. not on the front opening (Consider PN – seek advice from HSE Mechanical Specialist Group via the ELO)
- Lack of suitable ballast or other arrangements for anchorage on hard standing (PN)
- Lack of adequate supervision for the device i.e. one attendant managing several devices. (Consider PN)
- No means for measuring wind conditions i.e. anemometer (PN)
- Operating in wind conditions in excess of 38km/h or in excess of those specified within the OM (if less than 38km/h). (PN)
- No means of measuring internal pressure of device available i.e. manometer (possible PN)
- Wall heights for containment of users not inadequate (PN)
- Entrapment risks for head/neck and fingers present (PN)

Ground Pegs



Guidance

- **HSG 175**
- **BS EN 14960 – 'Inflatable play equipment – safety requirements and test methods'**
- <https://www.pipa.org.uk/> (Check PIPA tags and inspector details)
- <http://www.adips.co.uk/> (Check D.O.Cs and find safety alerts etc)
- **NFIT OG contains an IEE table for common issues under Appendix 16**
<http://www.hse.gov.uk/foi/internalops/og/og-00102.pdf>
- **PIPA guidance note available via HELEX**
- <https://www.pipa.org.uk/files/is05-securing-inflatables-on-hard-standing-outside.pdf>

THE END