

Maximum Jail Term for Plant Hire Manager Following Fatal Incident

Description

In a landmark case, a 57-year-old manager of an access plant hire firm was sentenced to the maximum penalty of two years' imprisonment. His neglect of health and safety obligations led to the death of one man and serious injury to another. After a 16-day trial at Airdrie Sheriff Court, Donald Craig was found guilty of breaching health and safety legislation.

On June 20, 2012, Gary Currie, a safety net rigger, and Alexander Nisbet, a self-employed operator contracted by Craig Services, were working on a platform at Buchanan House office block in Glasgow. They were removing netting from the facade when the third main boom section buckled. This caused the platformâ??s basket to plummet 28 meters to the ground. Tragically, Alexander Nisbet sustained serious injuries while Gary Currie was fatally injured.

This fatal incident was not the first involving the platform. In May 2011, Craig Services & Access Limited had instructed a repair to the damaged section of the main boom. This repair was incorrectly carried out. J M Access Solutions Ltd also failed in their duty to conduct a thorough examination of the platform.

Sentencing and Fines

Donald Craig was convicted of health and safety breaches and received a two-year prison sentence, the maximum penalty possible. Hamilton-based Craig Services and Access Limited was fined £61,000 after being found guilty of three charges related to the collapse, including maintenance failures. J M Access Solutions Ltd faced a £30,000 fine for not conducting a systematic and detailed examination of the platform and its safety-critical parts.

Gary Aitken, Head of the Health and Safety Division, commented: â??This incident, which resulted in the death of Gary Currie and caused serious injury to Alexander Nisbet, could have been avoided. Donald Craig and Craig Services & Access Limited failed to heed advice and take measures to maintain the platform safely. The decision to instruct this repair left Gary Currie and Alexander Nisbet exposed to unacceptable risk, essentially making the accident inevitable. A MEWP is a safety-critical piece of equipment, and it was foreseeable that such a repair would endanger the lives of those using it.â?•

Impacts and Implications

The incident has left family and friends devastated by the loss of a loved one. Aitken expressed hope that this prosecution would remind other employers that failure to fulfil their obligations can have tragic consequences and that they will be held accountable for their failings.

HSE Principal Inspector Graeme McMinn added: â??The death of Gary Currie was entirely



preventable. Craig Services and Access Ltd and Donald Craig were advised by the manufacturer to replace the damaged boom. Instead, they chose a cheaper repair that left the boom in an unsafe condition. The British Standard â??Safe Use of MEWPSâ?? advises that repairs to any parts of the MEWP structure should be in accordance with the manufacturerâ??s procedure.

â??At the time of the accident, the MEWP had numerous defects, some of which were safety-critical. This demonstrated that Craig Services and Access Ltd lacked an adequate maintenance and repair system. For a complex piece of equipment like the MEWP, such a system should include daily pre-use checks, intermediate inspections, maintenance based on manufacturer recommendations, and six-monthly thorough examinations by a competent person independent of the MEWP owner.â?•

Key Takeaways

The competence and diligence of a thorough examiner are vital as they declare the MEWP safe to use. JM Access Solutions Ltd failed to carry out a diligent examination and declared the MEWP safe. The British Standard provides guidance on what an examination should include following a major repair on a MEWP structure. Non-destructive testing and load testing should have been carried out, with overload testing discussed with the manufacturer.

â??This tragic accident highlights the absolute duty for owners of MEWPs to maintain them to ensure continued safe operation,â?• McMinn concluded.

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