

ICL INQUIRY
CONCLUDING SUBMISSIONS
on behalf of
THE FAMILIES AND SURVIVORS
represented by
PATRICK McGUIRE, THOMSONS,
SOLICITORS

Introduction

- [1] There are three sections to the concluding submissions made on behalf of these core participants.
- [2] In section 1 a number of particular observations are made in connection with the evidence on why the disaster occurred.
- [3] Section 2 focuses on the recommendations that the Inquiry may wish to adopt.
- [4] The final section of these submissions contain a number of observations that reflect the views of these core participants.
- [5] As before, the ICL entities are referred to as "ICL". The tank suppliers are referred to as "Calor" and "J Gas". The Health & Safety Executive is referred to as the HSE.

Section 1 : Particular Observations

ICL

- [6] In the submissions made on behalf of these core participants in Phase One it was suggested that in its dealings with the HSE, ICL pursued a policy of evading its responsibilities towards health and safety, a policy that was pursued at management

level. The policy was not simply one of evasion but of deception. The findings in fact proposed by these core participants ([53]-[56]) support that conclusion. It is perfectly plain that ICL at management level realised at an early stage in their dealings with the HSE that they could outwit the HSE inspectors. They were able to rely on the naivety of the inspectors to pursue a policy towards the safety of the LPG system that paid scant regard to the safety of the workforce.

- [7] The HSE's approach to the buried pipe work and to the existence of what was an unventilated void should not detract from the fact that ICL did not make any real attempt to understand their duties under the Health & Safety at Work Act 1974 and the relevant regulations, for example the Management of Health & Safety at Work Regulations 1992 and the Dangerous Substances Explosive Atmospheres Regulations (DSEAR) 2002.
- [8] ICL's deliberate failures in a situation where they placed their workforce at significant risk mean that ICL must bear the primary responsibility for the disaster.

The HSE

- [9] Phase Two of the Inquiry has highlighted that HSE inspectors in the 1980s failed to have proper regard to HSE internal guidance in the shape of FIC286/43 (issued 5/12/80) and FIC286/43 (RV) (issued 4/11/83). That internal guidance provided inspectors with an obvious insight into the risks of failure of LPG pipe work caused by corrosion. Such guidance was also available in HS(G)34 (1987) "The Storage of LPG at Fixed Installations". HSE knowledge should have been reinforced by the existence of Codes of Practice produced by the industry. As Mr Sylvester-Evans explained in his first Report (9th March 2007) the LPG ITA Code of Practice of November 1974 stipulated that "*buried pipelines shall be surveyed for leakage at a frequency dictated by the risks associated with their location, pressure of operation and aggressiveness of their environment*". That guidance was also contained in the LPG ITA Code of 1986 "Periodic Inspection and Testing".
- [10] Furthermore, after the construction of the basement floor in 1980 and consequently the creation of an unventilated void, the HSE inspectors who visited the premises after

that time ought to have focused on the fact that the LPG pipe work passed through the basement area. After the creation of the basement, in the period from June 1981 to February 1992 HSE inspectors carried out ten visits to the premises during which some focus was on the LPG system. In his Report of August 1988 Mr Tyldesley in recommendation 10 focused on the "T joint" in the LPG pipe work in the basement but failed to make any recommendation about the basement itself. The fact that the basement was an unventilated area is of particular importance to the cause of this disaster. Quite rightly much of the focus has been on the pipe work but a gas leak *per se* into the atmosphere would not have led to an explosion. HSE guidance in the shape of HS(G)34, "The Storage of LPG at Fixed Installations" para.78 warned against the risks of leakage in unventilated spaces by providing that if LPG pipes had to be routed through a building "*any such piping within the building should be in a well ventilated position protected from physical damage.*"

- [11] The HSE should not have failed to insist upon the recommendation made by Mr Tyldesley that the LPG pipe be partially excavated. Had the excavation proposed by Mr Tyldesley been carried out the absence of corrosion protection would have been evident. In any event the fact that no dense wrapping could be seen on the riser pipe that was visible should have alerted the HSE to the possibility that there was no corrosion protection to the LPG pipe work.

Calor

- [12] Having intervened on behalf of ICL in late 1988/January 1989 Calor should not have proposed a course of action that was designed to persuade the HSE not to insist upon the recommendation for partial excavation. The position adopted by Mr Betts that industry practice only required a tightness test is untenable. As discussed in paragraph [9] LPG codes of practice highlighted the importance of assessing the risk to pipe work from corrosion having regard to the aggressiveness of the environment in which the pipe work was located. A tightness test might be acceptable if you know what is there. Calor did not know the condition of the pipe work and whether it was protected against corrosion. That was the fundamental flaw in the Calor approach.
- [13] Furthermore, and in any event, Calor ought to have realised that the absence of corrosion protection on that part of the pipe work that was visible above ground

demanded that they satisfy themselves as to the position regarding the remainder of the LPG pipe work.

Section 2 : Recommendations

Rod Sylvester-Evans

- [14] There has been no significant challenge to the recommendations advanced by Mr Sylvester-Evans (RSE). It is submitted that the RSE proposals form a sound basis for dealing with the problems that have been raised during the Inquiry. We are content to make the following observations.
- [15] RSE has put forward a package of recommendations that are heavily interlinked. Great caution should be exercised in selecting some recommendations and discarding others.
- [16] He has emphasised the need for clear guidance and clarity in respect of who is responsible for what. That means that the "ownership" of individual responsibilities has to be encouraged.
- [17] His recommendations mean that there has to be adequate knowledge and competency available and independent review and monitoring.
- [18] The high risk sites have to be identified and as a priority any metallic pipe work removed. According to the evidence of Mr Elliot (J Gas) this is already being done and, so far as their customers are concerned, by June 2009 all metallic pipe work will have been removed.
- [19] At the heart of the package proposed by RSE lie the Safety Dossier and the verification scheme. If this two pronged approach is to be successful it is clear that the industry and the HSE require to work closely together.
- [20] We would support the conclusion that it should be a criminal offence for a supplier to supply LPG to a user and a user to use an LPG system if that system did not have an

up to date verification certificate. A criminal sanction would provide a way of guarding against rogue users of LPG and, conversely, protect the responsible suppliers of LPG. In the circumstances disclosed in the course of this Inquiry, ICL can be characterised as a rogue user of LPG. They failed to follow regulations that were directed to health and safety and, as already indicated, engaged in a policy of deception in their dealings with the HSE. Had there been a verification scheme of the kind envisaged by RSE, ICL would not have been able to get away with that approach, and the disaster would not have happened.

- [21] We also support the proposal that the Gas Safety (Installation & Use) Regulations 1998 (GSIUR) should be extended to cover industrial premises. The need to have a registered and competent person install, alter and monitor gas fittings (CORGI/CAPITA) would provide added safety for industrial premises using LPG.
- [22] An issue that has arisen particularly during Phase Two is the extent to which LPG suppliers should be responsible for the integrity of the equipment at a site. RSE has produced cogent reasons (Summary Note on Parties' Views of RSE Recommendations - paragraph 22) for the LPG suppliers' responsibility to extend only to the tank and fittings and not the service pipe work. In the course of Phase Two Mr Betts suggested that Calor's policy was that the vapour offtake valve was the cut off point. It seems that the rest of the industry use the first stage regulator as the point to which the suppliers' responsibility extends. There is a certain logic in using the first stage regulator as the cut off point because that would mean that the gas supplier would remain responsible for the high pressure side of the system.
- [23] To repeat what was said in the Recommendations Document, in their dealings with ICL the HSE failed to carry out proposed check visits. This was a clear systems failure. The HSE systems should be sufficiently robust so as to ensure that proposed inspections to check whether or not recommendations have been put in place are carried out.

Section 3 : Concluding observations

- [24] The Inquiry will note that a number of the core participants who we represent were in attendance at the Inquiry on a regular basis. Although the evidence was frequently upsetting to them, they were able to gain a clear insight into the cause of the disaster. We have been instructed to advise the Inquiry that they do feel that the truth of what happened has come out.
- [25] It is a matter of extreme importance to those we represent that this must not be allowed to happen again.

Colin MacAulay Q.C.
Gordon Lamont, Advocate