

ICL INQUIRY STATEMENT

ANNETTE RENATE LEPPLA

1. My name is Annette Renate Leppla. I am employed by the Health & Safety Executive (HSE) as one of HM Inspectors of Health and Safety and am based in 375 West George Street, Glasgow. I hold a postgraduate diploma in Occupational Health & Safety from Heriot Watt University. Currently I am working as an inspector in the Construction Division based in Glasgow. I have been an inspector for six and a half years.
2. I started my training with HSE in October 2001. At that time, the training period was two years. I spent my two years as a trainee inspector in the Engineering Group in Glasgow where my Principal Inspector (PI) was Ian Bowie. I was what is called a Band 4 Inspector, which is the trainee inspector job band. After successful completion of the two year training period you become a Band 3 Inspector. I was re-banded to Band 3 in October 2003. I spent all of my time as a trainee in Ian Bowie's group.
3. I started my postgraduate course at Heriot Watt in October 2002 when I, along with other trainees from the office, attended full time for six months. I returned to the office from Heriot Watt on 22 April 2003. In June 2003 I was in month 21 of my 24 month training period.
4. I visited the premises of ICL Plastics Ltd in Hopehill Road in Glasgow on 11 June 2003.
5. An ill health complaint from an ICL employee had been received by one of the complaints officers at the HSE office in Glasgow some time before 11 June 2003. The Principal Inspector sees all complaints received and decides what should be done. He put the ICL complaint out to me for investigation within a certain timescale. I cannot now remember what that timescale was.

6. I was given the complaints form containing the details provided by the notifier, that means the person making the complaint. The papers were marked up as JV (PI), that means for joint visit with Principal Inspector. I don't know why it was put out for joint visit.
7. The complaint was about the notifier's son's ill health which the notifier believed to be work related. The **record of this complaint on the computer system [ICL/ 012831]** in use at the time for recording our work, called "Focus", contains a summary of the information provided by the notifier over the telephone and was recorded by the complaints officer and says that the son was suffering breathing problems due to exposure to cement fumes in plastics fabrication, allergies, that there was no local exhaust ventilation system and that masks were not provided to all who required them.
8. Details would have been taken by the complaints officer over the phone. A complaints officer has a set of script of questions to ask a notifier. The complaints officer is a member of admin staff, not an inspector. They try to get as much detail as they can from the complainant. Part of their role is to explain the issues of anonymity and discloseability.
9. The complaint officer's form has areas on it to deal with the issues of anonymity and discloseability. Discloseable means that an investigating inspector can disclose to the duty holder that a complaint has been made, that means you can say "we have received a complaint". Anonymity is as it suggests – we do not reveal the identity of the complainant to the duty holder. Sometimes the complainer will not even tell us who they are.
10. Within HSE we tend to refer to companies and also individuals as "duty holders", that means anyone who has health and safety duties under the relevant statutory provisions.
11. My recollection is that this complaint was discloseable by the time it got to me and that there had been some discussion regarding anonymity. I recollect that the notes on the complaints form indicated that the notifier did

any enforcement notices served on the company in the past and to see if they were marked as having been complied with.

18. Focus records go back to about 1996 so only work recorded from then onwards is available to look at on the computer.

19. The computer records showed that enforcement notices had been served on the company so I looked to see what they were. HM Inspector of Health and Safety Cameron Adam had served those notices in 2000. This was the last visit before mine on the system. I went, therefore, to get the paper file from Focus filing to have a look at these notices [ICL/ 12246].

20. The Focus paper file showed that there were two prohibition notices for machinery guarding and an improvement notice in respect of COSHH assessments [ICL/ 12382]. "COSHH" is short for the Control of Substances Hazardous to Health Regulations, which requires employers, among other things, to make a suitable and sufficient assessment of the risks posed by such substances to their workforce. I looked through the letters and dates and was looking for something to show me that the COSHH assessments had in fact been carried out, as per the requirement of the notice. I saw a chasing letter from Cameron Adam to the company dated towards the latter part of April 2001.

21. I went back to the computer and saw that the "notice status" field on the screen read "complied", with a date of 30 April 2001. I made a manuscript addition to that effect on the copy of **Cameron Adam's chasing letter** on the paper file and initialled it on the letter [ICL/ 012832]. He had written on the 23 April and the compliance date was 30 April. To me this indicated that the notice had in fact been complied with and that compliance had been checked even if there were no documents regarding this on the paper file.

22. In terms of my visit to the site, there are things that I do recall directly but there are many things that, if they weren't on the Focus entry, I wouldn't remember at all.

23. We did not make arrangements with the company prior to our visit. We did not announce our visit to the company.
24. I do recall that myself and Michelle got there on 11 June 2003 and explained to reception who we were and that we wanted to speak to whoever was in control of the premises at ICL. We were received by Stewart McColl, who was introduced to me as the Managing Director of the company.
25. Initially we met in his office. Initially we spoke only with him but were later joined by Ian Mavers. I thought at the time that his name was Ian Maves, hence that spelling on my computer entry. He is described in my entry as a quality manager.
26. I was leading the visit, explaining in a roundabout way what we were doing. I didn't want to just blurt out "Mr Connelly is making a complaint". I was working up to saying a complaint had been made when Stewart McColl jumped in and said he knew exactly who and what we were talking about and mentioned Laurence Connelly's name. I confirmed that he was correct, that Laurence Connelly had made a complaint.
27. I discussed that we were there to investigate this ill health concern in order to determine whether it was work related, i.e. whether it related to the use of hazardous substances on the premises and whether a better control of those substances was required.
28. We had various conversations and cannot say the order in which they happened.
29. I recall having a conversation regarding employment relations at the factory, this information being volunteered by Stewart McColl. He described his management style as hands on and told us that since taking over the running of the firm a small core of employees were unhappy with his style of management. This followed on from a question I asked as to whether there

was a trade union or safety rep (representative) here as when they exist it is part of our instructions to meet them, and it's a good idea to meet them early on in the visit. I was advised that there was no union and no safety rep.

30. Stewart McColl had also explained to me the different companies that form the ICL Plastics Group. Stockline was described as a warehouse and so was local authority enforced, and not enforced by the HSE.

31. I recall at some point I asked to see what the company had in terms of their COSHH assessments and at that stage Stewart McColl moved our meeting to a conference room where there would be more room to look at the documentation.

32. I was shown two lever arch files, one containing general workplace risk assessments and the other containing COSHH assessments. I very briefly looked at the general one and then looked at the COSHH folder. I saw a large collection of data sheets and other documents. I sampled a small number of the documents contained in the folder and what was there appeared to satisfy requirements.

33. I asked the company some questions too, to probe their understanding of COSHH legislation. I asked about substitution and the hierarchy of control measures, as required by the COSHH Regulations.

34. Substitution means the duty holder should investigate whether it is possible to replace hazardous substances with substances that were less hazardous.

35. Hierarchy of control measures means, the duty holder needs to go through a sequence of steps, starting at the top, with the most effective control measure which is not to use a particular hazardous substance at all, but if that cannot be achieved then to the next level of control measures down, such as engineering controls like enclosure of the process to reduce the number of operatives exposed, but if that cannot be achieved or does not reduce the risk

sufficiently down to the next level of control measures, such as personal protective equipment, information, instruction and training.

36. From the answers that I received back, the company demonstrated a good understanding of the subject matter. They did advise that they had managed to substitute a number of substances already. I advised them that they should continue looking at substitution.

37. I asked to see Laurence Connelly Junior's workplace on the shop floor. Ian Mavers accompanied Michelle and myself to the shop floor. We were pointed towards an enclosure within a workshop. We were told that was where the cementing was going on and that was the work activity that Laurence Connelly was particularly concerned about.

38. The enclosure was an extracted booth within the workshop. Extracted means there was local exhaust ventilation removing air from the booth and replacing it with fresh make up air. There was one person working in there when we visited who Mr Mavers told me was Laurence Connelly Senior. I went off to speak to Mr Connelly Senior, leaving Ian Mavers and Michelle behind.

39. I introduced myself to Laurence Connelly Senior and gave him my card. I explained what I was there to do. He was wearing a half-face respirator but he did take it off to talk. I noted it had a brown cartridge on it, that is for use with organic solvents. He was working with solvents therefore the respirator was appropriate.

40. I hadn't been aware of the presence of an extracted booth at the time of the complaint being made, indeed the complaint was that there was no local exhaust ventilation, therefore this was news to me. Laurence Connelly Senior told me that this was a new booth.

41. I asked him if he thought that this made a difference and he said yes it did, that it made a big difference. He stated that for a long time before there had been no extraction.
42. I advised him I could only assess the control measures based on what they are now, not what they might have been in the past.
43. I told him that if recommendations were made to the company following my investigation, I would let him know those recommendations and the outcome generally of my investigation.
44. I took my leave and rejoined Ian Mavers and Michelle Gillies. We carried out a partial inspection while also still looking at areas that were relevant to the principal reason for us visiting ICL, namely the investigation of Mr Connelly's ill health, together with a selection of the "Revitalising" priority topics.
45. The priority topics under the "revitalising health and safety" agenda were falls from height, workplace transport, slips and trips, musculoskeletal disorders, stress, noise, hand arm vibration and occupational asthma. This was a new approach to inspections. These were the topics inspectors were to look at during inspections plus any "matters of evident concern".
46. FOD (short for Field Operations Directorate) Briefing Specials were issued in January 2002 and March 2002 on "Revitalising FOD" to assist inspectors in this new approach and to give guidance regarding what constituted "matters of evident concern". An interpretation was given in the **FOD Briefing Special January 2002 issue [ICL/ 012833-012836]** with a clarification provided in the **FOD Briefing Special March 2002 issue [ICL/ 012837- 012838]**.
47. Matters of evident concern at that time, as I understood them, were matters that were considered to be immediately dangerous and evident as

such, such as a padlocked fire exit. Issues that are raised by safety reps, employees or management could also be treated as such.

48. Because of the prohibition notices that had in the past been served in respect of machinery guarding, this was of concern to me although it was not relevant to my investigation of the ill health complaint and not a priority topic at the time of my visit, so I considered that it should be looked at.

49. As such, we were taken to the section where routers were being used. They were cutting plastic into different shapes. It is difficult to guard routers; wooden jigs are used to guide a work piece, keeping hands away from the danger zone. Some of the jigs in use were quite small and therefore operators' hands still went close to the danger zone.

50. In this instance I spoke to one of the operators about this. He explained what he was doing. We didn't think there was anything more that could be done in relation to the guarding of the routers so agreed that back at the office we would check to see if there was any additional guidance that could help us and contact the company if there was more they could do. In the event we found no advice other than what the company was doing already, i.e. using jigs, that would assist.

51. After leaving the router area we went to a powder coating area. I am not sure if this was an area complained of but because the complaint was about breathing problems I thought the dust generated in the powder coating area might be relevant, and therefore a visit should be made.

52. When I arrived at this area I don't recall any actual powder coating going on. I stood next to containers. Mr Mavers explained the process, in that generally they would take the box of powder and tip it into the containers. It was confirmed to me that they were doing manual tipping and I knew that this can give rise to a cloud of dust. If spillages occur and they are dry brushed then this will form a further cloud and therefore I advised them on

work methods that would minimise the dust and suggested to them that they should not dry brush.

53. I recommended that whoever was tipping or cleaning should wear a respirator or a disposable dust mask. I do not know if those measures were already in place or not. There was some contribution from me, some from Michelle. We were simply giving general advice.

54. At one point during the visit, and I do not recall whether this was before or after the powder coating area, we stood in another area on the shop floor and talked generally and Mr Mavers warned me not to touch a nearby surface which he explained was very hot as it belonged to a curing oven. I advised a warning sign to be put up regarding the hot surface. Mr Mavers remarked on the company's plans to potentially upgrade their ovens. We then moved on to another area.

55. I did not go into the basement. I did not check, or inspect, ovens within the factory or any associated pipework. When I was interviewed by Strathclyde Police in 2004 in the course of the criminal investigation into the explosion at ICL I was asked whether I had inspected or checked the Liquefied Petroleum Gas (LPG) tank and associated pipework during my visit. I stated that I did not. I do not now even have a recollection of seeing an LPG tank on site and certainly neither inspected nor checked it or any associated pipework.

56. After the shop floor visit we had another brief meeting with Stewart McColl and I let him know what areas we had looked at, repeated in summary form the advice we had given on the shop floor and told him we would contact him if we needed further information, if we had further advice to pass on and to let him know of the outcome of the ill health investigation when possible. I also told him that I would send further advice leaflets on COSHH and local exhaust ventilation. We then left the premises.

57. The extracted booth I had seen on site was described to me as new, so I thought the company would find guidance sheets on maintenance and testing helpful for the future. I also recall that we had a new style COSHH leaflet which hadn't been available before. My intention was to send those leaflets out. I cannot recall whether I sent the leaflets or not.

58. I visited the company once and that was on 11 June 2003 with my colleague Michelle. I have not visited it since.

59. After the visit I recorded both the investigation and inspection elements of my visit in accordance with instructions current at the time, wrote up a narrative of the visit on the computer system, completed a form IRF1 (Inspection Report Form 1) for the inspection and, based on my visit, rated various aspects of the duty holder's performance. The ratings reflect the overall satisfactory conditions and control measures I observed in the areas I saw during my visit [ICL/ 12247].

60. At that time, some of the ratings were used to produce Category A lists for inspection the next year, that is a list of companies that have received very poor ratings and must be visited during the next work year to see if they have improved sufficiently to be rated out of Category A. These lists are compiled centrally within HSE. I don't know if these lists still get compiled now. I recall that generally the list would come out in early summer and then each group of inspectors had until about Christmas to do the visits allocated to them. If I had in fact rated ICL very negatively following my visit in 2003 it would not necessarily be the case that there would have been a visit before the incident in May 2004. In fact it would have been highly unlikely due to the timescales described above.

61. I recall that after my visit to ICL, the issue of being seen by the occupational physician was still outstanding and so we did not have the results. While the visit was over and the active part of this complaints investigation was over, I still wanted the medical opinion to either confirm that

there was no occupational background here or alternatively to say that in fact there was.

62. In August 2003 a fresh complaint came from Laurence Connelly Junior by telephone to a complaints officer whilst we were waiting for this information from the occupational physician. People in the office knew of my previous investigation so the matter was sent to me.

63. I discussed the matter with the Principal Inspector and my view was this this was substantively the same complaint. Based on the **complaints procedure version 15/05/2003 [ICL/ 012839- 012846]** current at that time it was for Ian Bowie to decide if he wanted to hold it as a new complaint or not. We discussed it and it was agreed that I would make limited telephone enquiries of the company, thus taking some action.

64. This second complaint was received around 11 August 2003 and the first letter from MP Ann McKechin was received on 13 August 2003. My PI showed the letter to me. There was every chance that the MP's letter had already arrived by the time the PI and I discussed the case.

65. It is my recollection that when I phoned the company I asked to speak to Peter Ferguson as I recalled having been told that he took to do with health and safety at ICL. I was told he was unavailable. According to my Focus entry I spoke to Ian Mavers. I told him that we had received a further complaint, and that I was looking for extracts from COSHH assessments for specific chemicals that had been referred to in the MP's letter, to inform the Principal Inspector's reply [**ICL/ 12247**].

66. I was also looking to find out generally what was happening at the factory given Laurence Connelly Junior's ongoing concerns.

67. I was told that the occupational physician had visited the company and taken datasheets and the company advised me that they too were waiting on his report. In fact this is most likely how I found out the name of the

occupational physician treating Mr Connelly Junior. I learnt that this was Dr David Watt and I got Dr Watt's contact details.

68. I telephoned Dr Watt and spoke to him myself to let him know of HSE's involvement and our interest in the matter. I said to him that if Laurence Connelly agreed to release his results, could he keep me informed and gave him my contact details.

69. ICL Plastics sent in their COSHH sheets as agreed. They came to me in the first instance. I briefly looked at the top sheet, saw that it was the information requested and passed them on to Ian Bowie to allow him to respond to the MP.

70. A few days later I received a **letter by Dr David Watt dated 29 August 2003 [ICL/ 012847]** and then a **second letter addressed to me directly a couple of weeks later on 17 September 2003 [ICL/ 012848]** in which Dr Watt advised that it was unlikely that Laurence Connelly's ill health was caused by exposure to chemicals at work and he considered that he could come back to work provided that it was in an area with no respiratory irritants. I passed both letters on to my Principal Inspector to keep him updated.

71. At that stage I felt I was justified in closing off my investigation concluding that the first complaint was not justified. At the end of a complaints investigation it is common practice to record whether the complaint was fully justified, partially justified or not justified, in capitals, for ease of reading this result by other inspectors looking through the Focus records later on.

72. Regarding the claims made in the first complaint regarding lack of local exhaust ventilation, uncontrolled cement fumes and lack of respirators, on the basis of the information gathered at my visit and subsequently the medical opinion received I concluded that the complaint had not been justified and recorded this on the computer.

73. In all cases the notifier, that is the original complainant, should be advised within five days of completing the investigation what the outcome is [ICL/ 012839-012846]. I did not contact the notifier to say the investigation was concluded. Initially this was because I was waiting for information coming from the occupational physician. Once that was received the MP's letters had taken over the situation and the matter was largely out of my hands.

74. My principal Inspector spoke to me about the MP's letters and showed me draft replies on occasion as the MP's letters were among other matters about things that I was alleged to have said, but I do not recall those conversations with my PI in any useful detail.

75. I am aware that the explosion at ICL in May 2004, causing the death of nine people, arose due to a leak of LPG. I had received some LPG training prior to my visit at ICL. It was covered in a process safety tutorial in March 2002 which was delivered by our development manager. It was not technical training, it was more what you needed to know regarding tank storage and separation distances. That's what I remember. I could not say if pipework was covered or not.

76. In terms of LPG inspection experience, at visits with my Band 3 colleagues or my PI as a trainee inspector, LPG tanks and where they were sited was looked at on some occasions. I do not recall underground pipework being part of inspections or discussions with duty holders. It is my recollection of that time that LPG tanks were not all that common. Much more frequently we inspected the storage of gas cylinders of various types, including LPG cylinders. At the time of my visit I had some awareness of the guidance concerning separation distances and siting aspects as contained in the Highly Flammable Liquids and Liquefied Petroleum Gases Regulations 1972. At the time of my visit in 2003 I was unaware of the LPG Codes of practice in place at that time or their contents.

I confirm that the contents of this statement are true.

Witness signature

Dated
