Court of Appeal judgment highlights importance of effective internal reporting procedures in relation to adverse events

The recent Court of Appeal judgment in *Howmet Limited v Economy Devices Limited* [August 2016] has highlighted the importance of ensuring that any health and safety incidents and other unforeseen adverse events which occur on site or the factory floor are reported up the line through the company hierarchy so that appropriate steps can be taken to avoid further occurrences and/or to secure contractual entitlements.

The case concerned claims by Howmet after a fire in February 2007 caused catastrophic damage to its factory in Exeter, where it manufactured turbine aerofoils and other precision components for the aerospace industry. The fire resulted in losses in excess of £20 million. Howmet alleged that it had been caused by the negligence and breach of statutory duty of Economy Devices Limited (“EDL”). The case has obvious parallels with *Trebor Bassett Holdings Ltd and the Cadbury UK Partnership v ADT Fire & Security* [2012], which also involved claims (in this case for breach of contract) following the destruction of a factory by fire.

EDL was the manufacturer of a device called a thermolevel which had been used by Howmet to monitor a process involving the dipping of metal castings into a series of tanks containing acid heated to a high temperature in order to expose the grain. The process involved a high risk of fire breaking out if the liquid in the tanks fell below a certain level, so one of the primary functions of the thermolevel was to switch off the heater when the liquid dropped below that level. A fire broke out when a plant operator mistakenly switched on the heater of an empty tank. The thermolevel sensor failed to operate and the tank caught fire. This occurred in the early hours of the morning when no one was present to stop the blaze spreading and causing extensive damage.

It was clear from the expert evidence relating to this incident and previous failures that EDL had failed to provide a safe product in breach of the Electrical Equipment (Safety) Regulations 1994.

Nevertheless, Howmet’s claims against EDL failed at first instance and Mr Justice Edwards-Stuart’s judgment was upheld on appeal. The key finding
was that Howmet were aware that they could not rely on the thermolevel since in an incident at the same factory less than two weeks before the disastrous fire the device had previously failed to switch off the heater and this had also resulted in a fire breaking out. On the previous occasion, the fire had been put out before it spread.

After the first fire, knowing that they could not rely on the thermolevels, Howmet had ordered a float switch as an alternative device to switch off the heater if the liquid level fell. Before the delivery and installation of the new device, Howmet continued to operate the process, relying on “operator vigilance” and a new procedure to ensure that the equipment was left in a safe condition when it was not attended. Unfortunately, these measures also failed resulting in the second fire which caused the disastrous damage.

Howmet argued that as a company it could not be fixed with knowledge that the thermolevels were defective, or of the failed measures which had been put in place, since these had not been brought to the attention of the company’s senior management by the factory technicians concerned (who were employed by Howmet).

However, the Court of Appeal held that the knowledge of the factory technicians was sufficient to fix Howmet with the relevant knowledge, since they had been entrusted with the task of maintaining and operating the process in a safe manner. The Court of Appeal accordingly upheld the first instance judgment in finding that the failure of the new procedure which Howmet had put in place to deal with the risk of fire had broken the chain of causation, and relieved EDL of any liability for the malfunction of the thermolevel.

**Lessons to be drawn**

The narrow lesson which can be drawn from the case is that once an end user is alerted to the dangerous condition of an item, if he voluntarily continues to use it thereby causing death, personal injury or damage, he normally does so entirely at his own risk. The Court of Appeal recognised that there may be exceptions when the end user has no choice but to continue using the item as before. In practice the exceptions are likely to be rare since the adverse consequences or risks of failing to continue to use the item would have to outweigh the risks of continuing to do so.

The wider lesson to be drawn is that businesses must ensure that they have effective reporting procedures which ensure that incidents at site/factory floor level which could have an impact on the wider business are drawn to the attention of senior management where necessary.

The *Howmet* case demonstrates that businesses cannot always rely on employees to report to senior management an incident which may have wider and more damaging consequences than are foreseen by the individuals

“Promoting a safe and pro-active reporting culture is important not only in relation to health and safety risks, but also in relation to any events which have a potential impact on contractual entitlements, particularly where there are time-barring provisions which would mean that the entitlements are lost if the events are notified late.”

"
concerned. In some cases, individuals may be deterred from reporting incidents where they are conscious of having some personal responsibility for the incident. (This does not seem to have been a significant factor in the Howmet case, although mistakes by Howmet’s employees had been a major factor in both fires breaking out.) Businesses should accordingly provide for reports of such incidents (including “near misses”) to be treated in a “no blame” manner to encourage disclosure and to enable measures to be taken to avoid future occurrences. The experience of the aviation industry has been that the safety culture has improved immensely since the spread of a “no blame” reporting environment in which it is recognised that 90% of all unsafe acts are the result of non-culpable slips, lapses and mistakes to which everyone is prone and which can only be reduced by applying lessons learned to improve the processes concerned at an individual and a corporate level. The Howmet case demonstrates that such a “no blame” environment could also benefit industry more widely.

Promoting a safe and pro-active reporting culture is important not only in relation to health and safety risks, but also in relation to any events which have a potential impact on contractual entitlements, particularly where there are time-barring provisions which would mean that the entitlements are lost if the events are notified late.

An obvious example is the requirement under clause 61.3 of NEC3 ECC for the contractor to notify a compensation event within 8 weeks of “becoming aware” of the event, failing which the contractor has no entitlement to the reliefs prescribed by clause 63 by way of payment of Defined Cost and extension of time. There may be circumstances (such as unforeseen adverse physical conditions) which are noticed in the first instance by site operatives. All businesses involved in construction should have requirements (which are monitored and enforced) to report any such matter up the management line so that the individuals responsible for notifying compensation events have the necessary information to make the notification in good time.

The Howmet case suggests that the knowledge of a contractor’s junior employee of the occurrence of a compensation event will be deemed to fix the contractor with knowledge of the compensation event, even if in breach of duty to his employer he fails to pass the information to his line manager (and so on up the company hierarchy to those with relevant authority and responsibility) such that the senior management of the company is not actually aware of the circumstances concerned. In this case, it is likely that the contractor would lose its entitlement to relief if it fails to notify the compensation event within the 8 week time limit prescribed by NEC3 ECC.

For further information please contact:

Tom Pemberton
Partner
T: +44 (0)20 7469 0416
E: t.pemberton@beale-law.com

October 2016