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Company and director fined after worker seriously injured

Summary

A company and its director have been fined after an employee was injured from a fall during the construction of eight new houses.

What happened?

The injured man had been working in one of the new properties when he fell through an open stairwell on 27 February 2022.

He fell onto the concrete floor below where he was found unconscious.

How did things go wrong?

A Health and Safety Executive (HSE) investigation found that the company had identified the risk of internal falls in their risk assessment process but failed to provide suitable measures to prevent them in this and other areas of the site. After the incident, three Prohibition Notices were served prohibiting further work at height activities on site until such steps had been taken.

The HSE investigation also found that company director failed to ensure that the necessary health and safety measures were implemented to protect employees and others, despite previous HSE interventions regarding work at height.

Had the company put in place commonplace measures, such as birdcage scaffolding, or fixed edge protection around the stairwell openings, the incident could have been prevented.

March 2024 HSQE Newsletter

What was the outcome?

The company pleaded guilty to breaching Regulation 6(3) of the Working at Height Regulations 2005. It was fined £40,000 and ordered to pay £1,857.96 in costs.

The director pleaded guilty to breaching Section 37(1) of the Health and Safety at Work etc. Act 1974. He was fined £2,000 and ordered to pay £1,857.96 in costs.



The open stairwell

More info

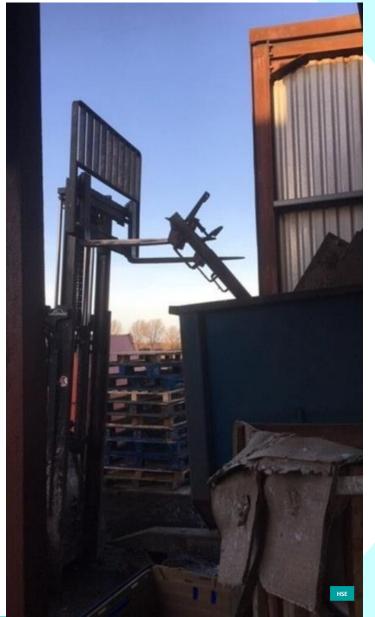
Guidance about safe working at height can be accessed at: https://www.hse.gov.uk/construction/safetytopics/ workingatheight.htm

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Worker killed in a fall from height from a skip



Summary

A company involved in fruit and vegetable production has been fined £320,000 after a man "who always put family first" was killed at a site in Burscough. The man suffered severe head injuries when he fell from a skip at a farm on 3 January 2020.

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What happened?

The man had been tipping food waste into a skip from a container attached to a forklift truck (FLT). The container could not be securely attached to the FLT, which was known to detach from the vehicle during the procedure. As he attempted to manually assist in the operation, he was standing on top of the skip when the container slipped from the FLT causing him to fall to the ground, resulting in fatal head injuries.

How did things go wrong?

An investigation by the Health and Safety Executive (HSE) found that the company had not fully assessed the risks involved in this daily task. Had they done so, the dangers would have been identified. They also failed to maintain equipment in safe working order and to properly instruct staff in safe working practices.

What was the outcome?

The company pleaded guilty to breaching Section 2(1) of the Health & Safety at Work etc. Act 1974. They were fined £320,000 and were ordered to pay £4,574 costs.

More info

Guidance on the provision and use of work equipment can be accessed at: https://www.hse.gov.uk/work-equipmentmachinery/puwer.htm Guidance on lifting equipment can be accessed at: <u>https://</u> www.hse.gov.uk/work-equipment-machinery/loler.htm

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The interlock guard on the

sliding doors was not working

Worktops firm fined after repeated failures to protect employees

Summary

A stone worktop manufacturer has been fined £26,000 for repeatedly putting its workers at risk. The company failed to implement safe working practices despite warnings from the Health and Safety Executive (HSE).

What happened?

The company consistently put their employees at risk from serious injury by failing to adequately guard dangerous machinery at their site. A HSE inspector visited the site in 2019 and enforcement action was taken to have the appropriate guards installed, and to introduce daily checks, to ensure these were in place and functioning correctly. When an inspector returned to the site on 18 August 2021, the guarding measures that had been put in place were broken or disabled – once again placing employees in danger.

How did things go wrong?

A HSE investigation found that the company had failed to properly manage, supervise, and monitor the control measures that had been put in place, in order to ensure that guards were being used as intended.



What was the outcome?

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work Act 1974 and were fined £26,000 and ordered to pay costs of £3,708.

More info Guidance can be viewed at: <u>https://www.hse.gov.uk/work-equipment-machinery/</u> introduction.htm



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Delivery driver suffered brain injury after a fall

Summary

A company has been fined £380,000 after a delivery driver fell and suffered a traumatic brain injury while working at its site in Walsall. The man was delivering fuel for a temporary diesel generator when he fell from a trailer on 28 July 2022.

What happened?

The man had been stowing equipment in a trailer attached to his truck when the vehicle was struck by a forklift truck reversing out of a nearby mill. This led to the trailer shunting into him causing him to fall and hit his head onto the tarmac floor below. He spent five weeks in hospital after sustaining a traumatic brain injury before spending 13 weeks in a care facility where he undertook CBT. He suffers from memory loss and dizziness as a result of his brain injury.

How did things go wrong?

A Health and Safety Executive (HSE) investigation found that the company failed to identify safe systems of work for the delivery of fuel to the temporary generators at its site. There was inadequate segregation of vehicles and pedestrians in the yard. There were no measures in place to prevent forklift trucks from entering the areas in which delivery drivers were working whilst refuelling generators.

The company understood the risks associated with workplace transport, as control measures had been identified for separating pedestrians and vehicles, but these had not been implemented. Site rules had been identified but were not routinely implemented or monitored by the company.



Fuel was being delivered to this temporary diesel generator

What was the outcome?

The company pleaded guilty to breaching Sections 2(1) and 3 (1) of the Health and Safety at Work etc. Act 1974. It was fined £380,000 and ordered to pay £5,934.50 in costs.

More info

Every workplace must be safe for the people and vehicles using it and traffic routes must be suitable for the people and vehicles using them. HSE has guidance on workplace transport with advice on keeping traffic routes safe and separating people from vehicles.

HSE guidance can be accessed at: https://www.hse.gov.uk/workplacetransport/

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Worker killed by loading shovel

Summary

A recycling company has been fined £2.15million after an agency worker was killed by a loading shovel.

The man lost his life when he was struck and run over in January 2020.

What happened?

The fatally-injured worker had been returning from the site's welfare cabins to his workstation on the picking line.

To do so, he needed to walk across a traffic area at the site where mobile plant, including two loading shovels, operated.

One of the loading shovels struck and killed him when he was walking in the traffic area.





The HSE investigation into the incident found that the company (which went into liquidation in 2021) failed to protect pedestrians from the mobile plant operations it was carrying out at the site. There were no suitable traffic management arrangements in place, meaning pedestrians were at risk of being struck by moving vehicles, including loading shovels.

Loading shovels are particularly dangerous if adequate segregation is not in place, in part due to the limitations to the operator's visibility around the machine – a HSE visibility assessment found that an area over 10 metres in front of the vehicle could be obscured from the driver's view.

What was the outcome?

The company was found guilty of breaching Section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007, Section 2(1) and Section 3(1) of the Health and Safety at Work etc Act 1974. The company was fined £1.75m for corporate manslaughter and £400,000 for breaching health and safety regulations.

Anything else?

The HSE inspector said: "Following the incident, it took the company less than a week to put in place an alternative traffic route to protect pedestrians. Had this been in place before the incident, [the fatally-injured man] would not have lost his life. Sadly, pedestrians being struck by vehicles on waste sites has caused many fatal accidents on waste sites and the industry should be well aware of the risks."

More info

Guidance on workplace transport can be found at: https://www.hse.gov.uk/workplacetransport/sitelayout.htm

Workers lost two fingers performing maintenance

Summary

An engineering firm in Perth has been fined £10,000 after an employee lost two of his fingers. The worker had been carrying out maintenance work on a grain dryer on 28 June 2020.

What happened?

The man inadvertently placed his hand into the blades of an unguarded rotary fan in the grain dryer. The fan was rotating at 1200 revolutions per minute when it came into contact with the worker's hand. This led to his little and ring fingers being amputated. He was off work for seven weeks following the incident.

How did things go wrong?

A Health and Safety Executive (HSE) investigation into the incident found that the company had failed to risk assess the task that the employees were required to undertake. On the day of the incident, there was no risk assessment for the work to be done nor was there any safe working procedure.

What was the outcome?

The company pleaded guilty to breaching Regulation 22 of The Provision and Use of Work Equipment Regulations 1998. The company was fined £10,000.

More info

It is important that clear information is given to workers when using machinery. Steps must be taken to prevent access to dangerous parts of machinery. HSE guidance can be found at: <u>https://www.hse.gov.uk/work-equipment-machinery/</u> puwer.htm



Worker's arm dragged into machine

Summary

A textiles company has been fined £60,000 after a man broke his arm when it was dragged into machinery. The employee suffered serious injuries to his right arm in the incident on 20 June 2022.





What happened?

The man had been operating a large fabric spooling machine when a brake malfunctioned and his sleeve was caught in a grooved spindle The company had neither guarded nor removed the exposed grooved spindle despite being aware of the risk it posed to employees. As a result of his injuries, the man, who was right-handed, spent four nights in hospital and was unable to return to work for six months.

How did things go wrong?

An investigation by the Health and Safety Executive (HSE) found the man had been operating a large fabric spooling machine when a brake malfunctioned. During his attempt to manually slow the rotation of the machine, his sleeve became caught up with an exposed grooved spindle and his right arm was drawn into the mechanism. It became twisted by the rotation of the machine which broke both major bones in the forearm and caused serious tissue damage.

What was the outcome?

The company pleaded guilty to breaching section 2(1) of the Health and Safety at Work etc. Act 1974. They were fined £60,000 and was ordered to pay £2,147 costs.

More info

HSE guidance can be accessed at: https://www.hse.gov.uk/work-equipment-machinery/ introduction.htm



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Machinery failings

Summary

A bedding manufacturer has been fined more than £250,000 after two of its employees were seriously injured during separate incidents at the same site.

The Health and Safety Executive (HSE) prosecuted the company following the incidents, which saw both workers undergo amputations.

What happened?

The first incident took place on 29 March 2020 and involved a 32-year-old employee. On his first day working on the line, he was instructed to clean the measuring wheel on a cutting machine. He climbed onto the conveyer belt, however the cutting machine had not been properly isolated from all sources of power and the machine's clamp came down, trapping the employee's left hand and causing the circular saw to move.

The saw was brought to a stop by another employee who pressed the emergency stop button. Unfortunately, this was not in time and resulted in the worker having three fingers amputated from his left hand.

The worker said in his victim personal statement: "Prior to this incident, I was a healthy, happy and active person. At the time I had one very young son, now I have two children. I try not to expose my left hand too much to my children when I am playing with them or when they are in my company. I do not talk about the incident with my children. When I am out and about in public, I try to keep my injured hand out of the public view."

On 22 October 2021, a second employee was involved in an incident while operating a quilting machine. The 51-year-old, had noticed a fallen casing and attempted to place it onto the back of the machine while it was being operated.

2002 - 2024

However, his gloves became tangled in the machine, causing his right hand to be dragged in. This caused lacerations and crush injuries to his right hand and resulted in the tips of two of his fingers to be amputated.

How did things go wrong?

The Health and Safety Executive (HSE) inspectors that investigated the incidents in 2020 and 2021 said that the company did not guard the machinery and did not implement suitable and sufficient procedures to isolate machinery from power.

HSE guidance says machines should be properly switched off, isolated or locked off before taking any action to remove blockages, clean or make adjustments. Machines should also be fitted with fixed guards to enclose dangerous parts, whenever practical.

What was the outcome?

The company pleaded guilty to breaching Section 2(1) of the Health & Safety at Work etc. Act 1974 and Regulation 11 of the Provision and Use of Work Equipment Regulations 1998. The company was fined £251,250 and ordered to pay £6,862.63 in costs.

More info

HSE guidance can be found at: https://www.hse.gov.uk/work-equipment-machinery/ index.htm

The cutting machine the employee was operating at the time

The guilting machine being used by the worker







Company and director are sentenced after an employee is crushed to death

Summary

A company and its director have been sentenced following the death of an employee. The man was crushed by two granite slabs while working on 30 November 2020.

What happened?

The 46-year-old, who was from Poland, had been unpacking and moving the slabs onto storage racks, using an overhead crane.

Two of the slabs, each weighing 250kg, fell and crushed him against a forklift truck while he was operating the crane's handheld pendant control.

He died at the scene despite desperate attempts from bystanders at nearby businesses and the emergency services to save him.

How did things go wrong?

A Health and Safety Executive (HSE) investigation found that the company and its director, failed to implement staff training or develop safe systems of work for the unloading, loading and handling of slabs. There was no evidence that employees had received training in the safe operation of machinery, including the overhead crane. The overhead crane and forklift truck had also not been thoroughly examined, as required by law, and that webbing slings, that could have been used during the unpacking process, were damaged.



Years

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What was the outcome?

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £18,000 and ordered to pay \pm 4,196.03 in costs.

The director pleaded guilty to breaching Section 37(1) of the Health and Safety at Work etc. Act 1974. He was ordered to complete 120 hours of unpaid work and pay £4,043.42 in costs.

More info

More information about lifting equipment and lifting operations can be accessed at: https://www.hse.gov.uk/work-equipment-machinery/

loler.htm

Vulnerable care home resident injured while unsupervised

Summary

A care home operator has been fined £400,000 for safety breaches, following the death of a vulnerable resident at a care home in Scotland.

What happened?

On the night of 16 December 2021, a resident (SG) could not be found on the premises.

Following a search around the site, care assistants found the 95-year-old in her nightwear lying in an external courtyard. SG had fallen and struck her head in the courtyard where she had been in the cold for some time. She was admitted to hospital and sadly died in hospital two days later.

How did things go wrong?

An investigation by the Health and Safety Executive (HSE) found SG died because she was able to access the courtyard while unsupervised and had fallen, spending up to an hour and a half outside before staff came to her aid.

What was the outcome?

The care home provider pleaded guilty to breaching Regulations Section 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. They were fined £400,000.

Anything else?

Health and safety guidance for care homes can be accessed at: https://www.hse.gov.uk/pubns/books/hsg220.htm



300kg of falling objects led to a serious injury

Summary

A recycling company in West Yorkshire has been fined £120,000 after batteries weighing at least 300kg fell onto an employee and severely injured him.

What happened?

The man was working with two colleagues when he was struck by the batteries being recycled on 22 March 2019. The three workers had been restacking the batteries that were stored in Flexible Intermediate Bulk Containers (FIBCs) after it had toppled over.

However, the FIBCs started to rip in front of them leading to the batteries falling on to one of the workers.

He suffered a double compound fracture to his lower right leg, a fracture to the left tibia, a fractured right collar bone, some bruising to his ribs and a cut on his forehead.

How did things go wrong?

A Health and Safety Executive (HSE) investigation found that the company failed to ensure the health, safety, and welfare of its employees at work. The site was overstocked, bags of batteries had been stacked in an unsafe manner and there was no specific documented risk assessments or safe systems of work for the correct stacking and storage of batteries. This was not an isolated incident.

What was the outcome?

The company pleaded guilty to breaching Section 2 (1) of the Health & Safety at Work etc Act 1974. The company was fined £120,000 and ordered to pay £4,937.39 in costs.

Anything else?

The HSE inspector said: "There are specific Industry Standards and Guidance relating to Flexible Intermediate Bulk Containers (FIBCs) which provides users with information on a range of aspects relating to their use including filling, discharging, handling and storage."

More info

HSE guidance says FIBCs must not be stacked unless the FIBC is designed to be stacked and only then should it be stacked in either a pyramid form or against two walls.

More information about waste management and recycling can be accessed at:

https://www.hse.gov.uk/waste/faqs.htm

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Unsafe gas work

Summary

An unregistered plumber has received a suspended prison sentence after he carried out illegal gas work at a house.

What happened?

The plumber attended the property on 31 January 2023 where he replaced a gas boiler and altered gas pipe work. However, he accidentally connected the gas supply with water, meaning the property's gas pipes and gas meter were flooded. Gas engineers later attended the property and had to pump water from the emergency control valve and replace the gas meter. The engineers classed the gas boiler he had installed as immediately dangerous, capped off the gas supply before notifying the Health and Safety Executive (HSE).

How did things go wrong?

The HSE found that the man has never been registered with the Gas Safe Register – a legal requirement. He also held no qualifications nor completed any training in gas work.

What was the outcome?

The plumber pleaded guilty to contravening Regulations 3(1) and 3(3) of the Gas Safety (Installation and Use) Regulations 1998, contrary to Section 33(1)(c) of the Health and Safety at Work etc. Act 1974. He was sentenced to six months in prison, suspended for six months, and ordered to pay £3,000 in costs.

More info

Information about gas work can be accessed at: <u>https://www.hse.gov.uk/gas/</u> Registered gas engineers can be found at: <u>https://www.gassaferegister.co.uk/find-an-engineer-or-check-</u> <u>the-register/</u>

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Worker fatally crushed during lifting operation

Summary

A company has been fined £120,000 after a worker was killed after becoming trapped between two heavy steel beams.

What happened?

He was using an overhead travelling crane to lift the middle of three beams to position it better on a trolley which ran on rails in the workshop. The beam he was lifting was 18m long and weighed 1,800Kg. As it was lifted, it rotated in a sling, toppling sideways and trapping him against another beam.

How did things go wrong?

The Health and Safety Executive (HSE) found that the company had failed to ensure a suitable and sufficient risk assessment was conducted by a competent person to identify well known industry standard control measures. Suitable and sufficient information, instruction, and training was not provided to employees about lifting operations at the site. The company did not properly plan lifts and did not have a system for ensuring that there were adequately qualified supervisors present during lifting operations.

What was the outcome?

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. They were fined £120,000 and ordered to pay costs of £50,000.

More info

More information about lifting operations can be accessed at: https://www.hse.gov.uk/work-equipment-machinery/loler.htm

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Woman's arm severed due to inadequate guarding

Summary

A scrap metal recycling company in Essex has been fined £200,000 after an employee's arm was severed when it became entangled in a catalytic converter sampling machine.

What happened?

The woman was working at a recycling facility on 12 June 2021 when she passed her hand through an unguarded rotary valve to remove a blockage.

The valve closed, trapping and severing the 34-year-old's right arm. Her right arm was later amputated as a result of the incident and she has been unable to work since.

How did things go wrong?

An investigation by the Health and Safety Executive (HSE) found that the company failed to prevent access to dangerous parts of machinery, namely the rotating parts of a rotary valve inside the sampling machine.

HSE guidance states employers must take effective measures to prevent access to dangerous parts of machinery. This will normally be by fixed guarding but where routine access is needed, interlocked guards (sometimes with guard locking) may be needed to stop the movement of dangerous parts before a person can reach the danger zone.

What was the outcome?

The company pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998. It was fined £200,000 and ordered to pay £5,125.37 in costs.

More info

More information about the provision and use of work equipment can be accessed at: <u>https://www.hse.gov.uk/work-equipment-machinery/</u> <u>puwer.htm</u>







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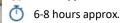
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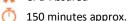


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- Q CPD Assured 90 minutes approx.
 - £6.50 £15.00 + VAT
 - In the Mix and Match 5 selection

Child Online Safety Awareness



90 minutes approx.

CPD Assured

- £6.50 £15.00 + VAT
- In the Mix and Match 5 selection

Child Sexual Exploitation Awareness



CPD Assured 90 minutes approx.

CPD Assured

£6.50 - £15.00 + VAT

150 minutes approx.

£12.50 - £25.00 + VAT

In the Mix and Match 5 selection

Designated Safeguarding Lead (Children)



w: vitalskills.co.uk e: info@hsqe.co.uk

Sorry not in the Mix & Match 5 selection

t: 0333 733 1111

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Online short food safety and hygiene courses

Food Allergen Awareness IoH. RoSPA & CPD Assured 90 minutes approx. £6.50 - £15.00 + VAT In the Mix and Match 5 selection Food Safety and Hygiene - Level 1 IoH, RoSPA & CPD Assured 60 minutes approx. £6.00 - £10.00 + VAT In the Mix and Match 5 selection Food Safety and Hygiene (Catering) Level 2 IoH. RoSPA & CPD Assured 90 minutes approx. £6.50 - £12.00 + VAT In the Mix and Match 5 selection Food Safety and Hygiene (Manufacturing) Level 2 IoH. RoSPA & CPD Assured 90 minutes approx. £6.50 - £12.00 + VAT In the Mix and Match 5 selection

Food Safety and Hygiene (Retail) Level 2



- IoH. RoSPA & CPD Assured 90 minutes approx.
- £6.50 £12.00 + VAT
- In the Mix and Match 5 selection



HACCP for Catering Level 2



- IoH & CPD Assured 90 minutes approx.
- £6.50 £15.00 + VAT In the Mix and Match 5 selection

HACCP for Manufacturing Level 2



IoH & CPD Assured 90 minutes approx.

£6.50 - £15.00 + VAT

In the Mix and Match 5 selection

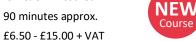


All of our food safety and hygiene courses are endorsed by the IoH

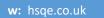




90 minutes approx.



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