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Latest HSE statistics reveal continuing health and safety challenges

Summary

The Health and Safety Executive (HSE) has released its latest annual data on work-related ill health and workplace injuries for 2024/25.

According to the report, around 1.9 million workers experienced some form of work-related ill health during the year, a figure that has remained relatively stable when compared with recent trends.



Although the current levels of self-reported work-related ill health are broadly similar to those seen over the past few years, they remain above the rates recorded before the pandemic in 2018/19.

> **Around 1.9 million workers** experienced some form of work-related ill health during the year.

Mental health issues continue to account for the largest share of work-related ill health. In 2024/25, approximately 964,000 workers reported experiencing stress, depression, or anxiety linked to their job, reflecting the ongoing upward pattern observed in recent years.

Work-related ill health and injury led to an estimated 40.1 million working days being lost in 2024/25, placing considerable strain on both employees and employers.

The report also draws attention to the financial burden arising from poor workplace health and safety. For 2023/24, the total cost associated with workplace injuries and new cases of workrelated ill health was estimated at £22.9 billion, a figure that is comparable with the previous year.

In 2024/25, workplace injuries resulted in 124 worker fatalities and around 680,000 self-reported non-fatal injuries.

More Information

The statistics can be accessed at: https://www.hse.gov.uk/statistics/index.htm



Worker fatally crushed by falling pallet in storage area

Summary

A worker died after being trapped by a falling pallet in a storage area. The company has been fined following an HSE investigation into unsafe pallet stacking practices.

What Happened

On 21 September 2020, a worker was fatally injured while working in a storage area at an industrial premises. A loaded pallet, weighing 592kg, had been stacked on top of another pallet at floor level. The upper pallet fell, trapping the worker against a wall ledge. Other employees attempted to free him, but the weight of the pallet was too great to lift. They had to unload it piece by piece before it could be removed. Despite their efforts, the worker died from his injuries.

The Investigation

The Health and Safety Executive (HSE) found that no suitable or sufficient risk assessment had been carried out for pallet storage arrangements. Investigators identified that:

- Pallets with three legs had been stacked vertically without racking systems.
- Load, height, weight, and stability factors had not been considered.
- These pallets should never have been stacked on top of each other in this way.

Although a pallet handling procedure existed, not all employees working in the relevant area had been trained on it, and there was no evidence that the worker who died had received any training on the procedure.



The court heard that failings included:

- Not undertaking a suitable and sufficient risk assessment for pallet storage.
- Not implementing measures to prevent double stacking or falling pallets.
- Not providing adequate training in safe pallet storage.
- Not ensuring effective monitoring and supervision of pallet condition and storage practices.

The Outcome

The organisation pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974.

It was fined £600,000 and ordered to pay £15,000 in costs.

Additional Context

Improperly stored pallets present significant crushing and stability hazards. Key controls include:

- Using appropriate racking systems.
- Avoiding vertical stacking of incompatible pallet types.
- Ensuring weight and stability are fully assessed.
- Providing clear procedures and ensuring all staff are trained and supervised.

More Information

Further information can be found in HSE's guidance: Pallet Safety – PM15. The document can be accessed at: https://www.hse.gov.uk/pubns/pm15.htm



Worker fell through unprotected skylight opening

Summary

A man died after falling through an unprotected skylight opening while assisting with work on a domestic property roof. The company involved has been fined following an HSE investigation.

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What Happened

Work was underway to construct a single-storey extension with a flat roof at a domestic property. Late on the evening of 20 July 2022, rain began to fall, prompting those involved to return to the site at around 11pm to cover the new roof with a blue plastic tarpaulin, which they secured with pieces of timber.

A member of the public accompanied one of the workers to the site. At some point, he went onto the roof to help and fell approximately 2.5 metres through an opening intended for a skylight, landing on the concrete floor below.

Instead of calling an ambulance, he was lifted back through the opening, carried across the roof, taken down a ladder, and transported to hospital in a van. He died a few days later from significant injuries, including a spinal fracture, fractured skull, and suspected brain injury.

The Investigation

The Health and Safety Executive (HSE) attended the site the following day. Between the police leaving at around 4am and the arrival of the HSE later that morning, the tarpaulin had been replaced, obscuring the roof area.

The investigation found that no physical safety measures were in place to prevent falls either at the roof edges or around the skylight openings. No controls were provided to reduce the distance or impact of a potential fall.

The company also failed to comply with a legal requirement to provide information requested by an HSE inspector under Section 20 of the Health and Safety at Work etc. Act 1974.



Tarp following the fall when police attended



Tarp covering roof/hole when HSE attended

The Outcome

The organisation pleaded guilty to breaching Regulation 6(3) of the Work at Height Regulations 2005 and Section 33(1)(e) of the Health and Safety at Work etc. Act 1974.

It was fined £33,500, ordered to pay £8,472 in costs, and given a £2,000 victim surcharge.

Additional Context

HSE guidance on planning and undertaking work at height sets out practical measures to eliminate or control these risks. In this case, following recognised guidance would have identified the unprotected skylight openings as a clear hazard and shown that the risk could have been fully removed by changing the approach to the work.

More Information

HSE guidance on working at height can be found at: https://www.hse.gov.uk/work-at-height/index.htm

Visitors infected with zoonotic disease following farm animal feeding activity

Summary

An animal feeding activity at a petting farm led to 264 visitors contracting cryptosporidiosis. The farm operator has been fined following an investigation by the HSE and UKHSA.

What Happened

During April and May 2023, visitors attended an animal bottle-feeding activity at a petting farm, where they could purchase milk to feed lambs or goat kids. The activity resulted in an outbreak of cryptosporidiosis, a highly infectious zoonotic illness, affecting more than 30% of attendees. Over half of those infected were children. Cryptosporidium is a parasite that causes gastrointestinal illness, with symptoms such as abdominal cramps, diarrhoea, and nausea. Following reports of illness among attendees, the outbreak was formally declared.

Approximately 2,400 tickets had been sold for the feeding activity between 4 April and 1 May 2023.



The Investigation

A joint investigation by the Health and Safety Executive (HSE) and the UK Health Security Agency (UKHSA) traced the outbreak to the feeding activity. Investigators identified significant failings in how the event was managed, including:

- Failure to properly assess risks to workers and visitors.
- Inadequate hand-washing and drying facilities, including the use of reusable cloth towels.
- Insufficient information and instruction provided to employees and visitors, including inadequate communication of zoonotic risks.
- Poor control and supervision of visitor contact with animals, with children observed kissing animals contaminated with faecal matter.

As a result, 264 people reported symptoms of illness. Five per cent required overnight hospital stays due to prolonged or severe symptoms. Adults also reported significant time off work and caring responsibilities, with 1,254 days lost collectively. Some individuals continued to experience gastrointestinal issues months later, including repeated hospital admissions during 2024. Victim statements described severe illness, fear for children's wellbeing, and lasting psychological effects.

The Outcome

The farm operator pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974. A fine of £8,000 was imposed, along with £9,528.35 in costs.

Additional Context

All animals carry microorganisms that can be passed to humans, known as zoonoses. Young children and individuals with weakened immune systems are particularly vulnerable to serious illness.

Cryptosporidium can survive for long periods in the environment, and only a small number of organisms are required to cause infection. People may become infected through consumption of contaminated food or water, by touching contaminated animals, or through indirect contact with animal faeces or saliva—for example, during bottle-feeding or by touching contaminated fences or towels. Those operating animal visitor attractions have a legal duty to assess risks and implement effective control measures. Good hand hygiene, including washing with soap and water, is essential.



More Information

Further guidance on controlling zoonotic risks at visitor attractions can be found in the ICOP: Preventing or Controlling III Health from Animal Contact at Visitor Attractions, which is available at:

https://visitmyfarm.org/resources/code-of-practice

New Mpox strain detected in **England**

Overview

A new strain of mpox (formerly known as monkeypox) has been identified in England. The case was detected in a person who had recently travelled in Asia. Early analysis shows the virus is a combination of two existing types of mpox, but officials say more work is needed to understand the implications.

Background

The UK Health Security Agency (UKHSA) confirmed that genomic testing revealed this strain contains elements of clade Ib and clade IIb, two recognised mpox lineages. Clade IIb was responsible for the global outbreak in 2022, while clade Ib has

more recently shown early signs of spreading in parts of Europe.

Health authorities emphasise that viral evolution is expected and does not necessarily indicate an increased threat.

What Officials Are Saying

UKHSA noted that vaccination remains the most effective protection against severe illness. Many mpox infections are mild, but the risk of complications remains, particularly for those with higher exposure.

The mpox vaccine is currently offered to those considered at higher risk of contracting the virus, including:

- People with multiple sexual partners
- Those who engage in group sexual activity
- Visitors to sex-on-premises venues

The vaccine is estimated to be 75-80% effective. While no studies have yet assessed its performance against this new strain, experts believe protection is likely to remain high.



Professor Trudie Lang of the University of Oxford noted that the UK has strong systems for identifying and controlling infections. However, she highlighted that global surveillance varies significantly and some regions face challenges accessing vaccines and healthcare. She stressed the importance of understanding how the new strain

spreads and how severe it may be if more cases emerge.

Dr Boghuma Titanji, an infectious disease specialist, warned that continued global circulation increases the chances of the virus evolving further. She suggested that wider spread provides more opportunities for the virus to adapt and become a more established human pathogen.

Global Situation

So far in 2025, nearly 48,000 cases of mpox have been recorded worldwide. Most recent cases have occurred in central Africa, where outbreaks remain a significant concern.

About Mpox

Mpox is known to cause an unpleasant illness, typically lasting two to four weeks. Common symptoms include:

- Skin lesions or rash
- Fever and headaches
- Back and muscle pain
- Fatigue

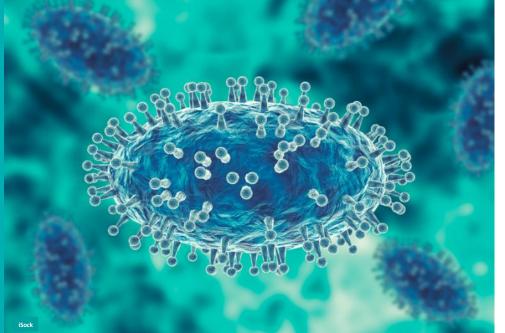
Transmission happens through close physical contact, respiratory droplets, or contact with contaminated materials such as bedding or towels.

Health officials advise anyone who believes they may have mpox to contact NHS 111 for guidance.

What This Means

The emergence of a new strain underscores the importance of continued surveillance, vaccination, and public awareness.

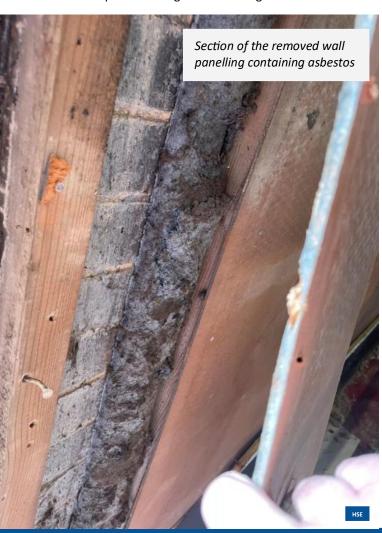
While there is no indication at this stage that the strain poses a heightened risk, understanding how it behaves will be crucial in shaping public health responses in the UK and internationally.



Asbestos disturbed during unassessed building work at film studio

Summary

A film studio has been fined after employees were put at risk of asbestos exposure during minor building works.



What Happened

On 22 July 2022, maintenance workers at a film studio in Hertfordshire were instructed to remove acoustic wall panels ahead of planned door replacement works by an external contractor. They were assured that no asbestos was present and began dismantling the panels using basic hand tools. Part way through the task, one worker noticed insulation he suspected to be asbestos and immediately stopped. Testing later confirmed that the material contained Amosite/Chrysotile and Crocidolite, which require licensed removal.

The Investigation

The Health and Safety Executive (HSE) discovered that neither the studio's asbestos management surveys nor its refurbishment surveys had examined the wall surfaces within three of the studio stages. Consequently, the panels being removed were not included in any assessment.

The investigation also revealed deficiencies in staff training and gaps in the emergency procedures required when asbestos is disturbed.

HSE guidance makes clear that no work involving a potential asbestos risk should take place without a suitable assessment and a clear plan. This typically requires the involvement of licensed contractors who are competent to manage asbestos safely.

The Outcome

The organisation admitted breaching Regulations 5, 10, and 15 of the Control of Asbestos Regulations 2012. It received a $\pm 6,000$ fine and was ordered to pay $\pm 6,790$ in costs.

More Information

See: https://www.hse.gov.uk/asbestos/

HSE seeks views on proposals to enhance protection from asbestos exposure

Summary

The Health and Safety Executive (HSE) has launched a consultation on proposals to improve the application of the Control of Asbestos Regulations and guidance around asbestos management to help protect workers and building users.

Background

The consultation aims to seek stakeholders' views on three proposals:

- To ensure the independence and impartiality of roles in the four-stage clearance process to further minimise the risk of exposure from asbestos to workers and building users after the removal of asbestos
- To drive up the standard of asbestos surveys to ensure dutyholders have the information they need to safely manage asbestos risks
- To clarify the type of work that constitutes work with asbestos known as Notifiable Non-Licensed Work (NNLW)

The consultation

The consultation runs until 9 January 2026.

The full consultation document, including detailed proposals, background information and how to respond, is available on the HSE website at:

 $\underline{https://consultations.hse.gov.uk/hse/proposals-control-of-asbestos-regs-2012}.$





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Unguarded machinery leads to fatal incident at poultry site

Summary

A worker died after his clothing became entangled in an unguarded feeding system at a poultry site in Cumbria.

What Happened

The fatal incident occurred on 11 January 2023 at a farm in Penrith. The 61-year-old worker, who lived locally, was carrying out tasks alone inside one of the poultry sheds.

During a scheduled feeding cycle, his clothing came into contact with an exposed rotating sprocket that formed part of the drive mechanism for the hen feeding system. His clothes became entangled, resulting in fatal injuries.

The man's family later expressed deep anger, stating that his life had been lost for the want of something as simple as "a 50 pence screw".

The Investigation

The Health and Safety Executive (HSE) found that access to dangerous moving parts had not been prevented. The guard intended to cover the sprocket was not fixed in place and could be lifted off with ease.

Further examination showed that bolt holes in the guard were stripped and did not align with those on the drive unit frame, making it impossible for the guard to be secured. As a result, the feeding system — which operated for short three-minute intervals throughout the day — posed a foreseeable risk whenever it ran.

HSE guidance makes clear that employers must implement effective measures, generally fixed guards requiring a tool for removal, to prevent workers reaching dangerous parts of machinery. This is the standard expected under PUWER.

The Outcome

The organisation admitted breaching Regulation 11(1)(a) of the Provision and Use of Work Equipment

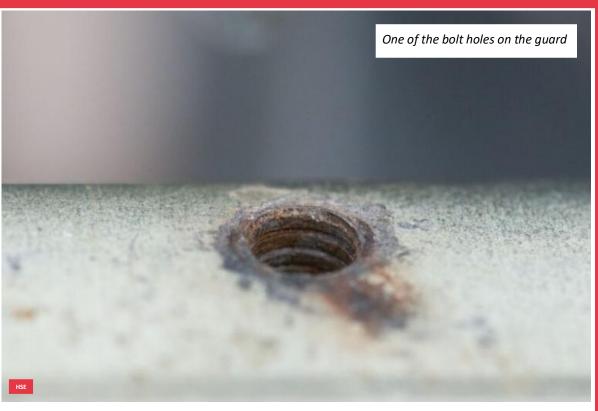
Regulations 1998. It was fined £50,000 and ordered to pay £6,038 in costs.

Additional Context

Effective guarding is one of the most fundamental requirements in preventing entanglement, crushing, and other machinery-related injuries. Regular inspections and maintenance of guards and fixings are essential to ensure they remain in place and fit for purpose.

More Information

See: https://www.hse.gov.uk/work-equipment-machinery/ puwer.htm





The machine was examined at HSE's site in Buxton

Worker fatally injured after becoming trapped in unguarded machine

Summary

A worker died after becoming trapped in the moving parts of an unguarded plastic conversion machine. The company has been fined following an HSE investigation.

What Happened

The incident occurred at a manufacturing site where a plastic conversion machine was in operation.

On 29 May 2020, a worker accessed an opening on the side of the machine that allowed full-body entry into an area containing dangerous moving parts. The mechanisms inside were unguarded, and the worker became trapped.

Emergency services attempted to free him by cutting conveyor belts and rollers, but he died at the scene from crush asphyxia.



The Investigation

The Health and Safety Executive (HSE) found that no suitable or sufficient risk assessment had been carried out for the operation of the machine. There was no adequate guarding to prevent access to dangerous parts, and no written safe systems of work or isolation procedures were in place.

HSE guidance requires employers to take effective measures to prevent access to dangerous parts of machinery. This is usually achieved by fixed guards, though interlocked guards may be necessary where routine access is required to stop movement before a person can reach the danger zone.

The Outcome

The organisation pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974.

It was fined £277,500 and ordered to pay £20,000 in costs.

Additional Context

PUWER (Provision and Use of Work Equipment Regulations 1998) sets out employers' duties in managing the risks associated with machinery.

HSE's Approved Code of Practice, Safe Use of Work Equipment, provides further guidance on appropriate guarding arrangements and the need for robust systems of work to prevent injury.

More Information

Further guidance on machinery safety can be found in HSE's resources on PUWER and the safe use of work equipment. https://www.hse.gov.uk/work-equipment-machinery/ puwer.htm



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Worker fell through skylight opening

Summary

A roofing contractor has been fined after an employee suffered serious injuries when he fell through an unprotected skylight opening while working on a domestic property.

What Happened

The incident occurred during work to recover a flat roof on a single-storey extension at a residential property in Northampton. As part of the preparation work, covers installed over two large skylight openings were removed. While removing material from one opening, the worker fell through the other uncovered opening, falling more than three metres to the ground below.

The worker sustained serious injuries that required surgery and long-term medical treatment.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the work at height had not been properly planned. Suitable control measures were not put in place to prevent workers from falling through the skylight openings during the task.

The investigation concluded that appropriate fall prevention measures, such as a crash deck or safety netting beneath the openings, would have significantly reduced the risk of serious injury.

The Outcome

The company pleaded guilty to breaching Section 3(1) of the

Health and Safety at Work etc. Act 1974. It was fined £16,650 and ordered to pay £7,205 in costs and a £2,000 victim surcharge.

Additional Context

HSE guidance states that employers must ensure work at height is properly planned, appropriately supervised and carried out in a manner that is, so far as is reasonably practicable, safe. This includes implementing suitable control measures to prevent falls or reduce the consequences should a fall occur.

More Information

See: https://www.hse.gov.uk/pubns/books/hsg33.htm

Worker seriously injured after fall from height during gutter replacement

Summary

A worker suffered multiple serious fractures after falling from height while replacing guttering on a domestic garage. The company has been fined following an HSE investigation.

What Happened

On 12 August 2024, a worker was instructed to replace guttering on a domestic garage building. He received no guidance on how to perform the task safely and was not informed that a shed next to the garage restricted safe access to parts of the guttering.

While reaching from the roof of the shed towards the final gutter bracket, he lost his balance and fell approximately seven feet to the ground. He sustained significant injuries, including fractures to his shoulder, upper arm, eye socket, and nose.

The Investigation

The Health and Safety Executive (HSE) found that the work had not been properly planned. No measures were in place to prevent a fall or to mitigate the consequences should one occur. The worker had not been provided with adequate information or instruction regarding safe access or the risks involved in the task.

The Work at Height Regulations 2005 require that all work at height be properly planned, appropriately supervised, and carried out safely. Guidance on achieving compliance is available through the HSE.

The Outcome

The organisation pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £16,500 and ordered to pay £5,994.55 in costs.

Additional Context

Falls from height remain a leading cause of workplace injury. Common failings include inadequate planning, reliance on unsafe access methods, and lack of supervision. Simple controls—such as using appropriate access equipment, ensuring workers understand the limitations of their surroundings, and assessing risks posed by nearby structures can prevent incidents of this kind.

More Information

Further guidance on safe working at height is available on the HSE website at:

https://www.hse.gov.uk/work-at-height/index.htm

VitalSkills HSQE

Young worker suffers broken arm after becoming entangled in manual lathe

Summary

An 18-year-old employee sustained a serious arm injury after becoming caught in a rotating manual lathe while deburring a component.

What Happened

The incident occurred on 1 December 2023 at a manufacturing site in Swadlincote. The young worker had been using emery cloth to deburr a component by hand, without any protective appliance to keep his hands clear of the rotating parts. His arm became entangled in the lathe, resulting in a broken arm.

The Investigation

The Health and Safety Executive (HSE) found that no safe system of work had been put in place for deburring activities, and no risk assessment had been carried out for the use of emery cloth on rotating machinery.

HSE guidance states that employers must

undertake a suitable and sufficient assessment of the risks associated with polishing, deburring, or sizing metal components using emery cloth on manual lathes.

The assessment should determine whether the task can be carried out without emery cloth. Where this is not possible, a safe method must be implemented, supported by clear controls and appropriate equipment. Further guidance is available on the HSE website.

The Outcome

The organisation admitted breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £16,000 and ordered to pay £4,357.77 in costs and a £2,000 victim surcharge.

Additional Context

Entanglement in rotating machinery remains a significant cause of serious injury. Safe systems of work, proper guarding, and avoidance of hand-held methods such as emery cloth use are essential controls in metalworking environments.

More Information

Guidance can be accessed at: https://www.hse.gov.uk/engineering/ lathes.htm



Worker fatally injured during devanning activity

Summary

A road haulage company has been fined £250,000 after a worker died when unsecured metal frames collapsed inside a shipping container during a devanning task.

What Happened

The incident occurred in the early hours of 8 January 2019 at a yard in South Bank, Middlesbrough. Two employees were standing up metal frames weighing around 120kg each inside a shipping container. As they raised the sixth frame, the fifth frame fell backwards, triggering a collapse of several others. One of the workers became trapped by the neck between the container wall and the fallen frames.

He suffered a cardiac arrest and, despite being taken to hospital, tragically died three days later.

The Investigation

HSE's investigation found that:

- The metal frames had not been secured to the container wall.
- The company had never undertaken devanning work before, yet failed to produce a suitable and sufficient written risk assessment.
- There was no clear safe system of work, and employees were left largely unsupervised to determine their own methods.
- Work practices were ad-hoc and unsafe, lacking planned controls for a high-risk manual handling activity involving heavy, unstable loads.

HSE concluded that the company failed to ensure, so far as was reasonably practicable, the health, safety and welfare of its employees while carrying out devanning tasks.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £250,000, with costs to be determined at a later date.

An HSE inspector stated that the death was tragic and preventable, emphasising the importance of suitable planning, clear risk assessments, and safe systems of work.

More Information

Further guidance on managing risks can be found on the HSE website:

https://www.hse.gov.uk/simple-health-safety/risk/stepsneeded-to-manage-risk.htm

Worker seriously injured by electrical flashover

Summary

A company providing wind farm management services has been fined after a worker suffered life-changing injuries as a result of an electrical flashover during maintenance work at a wind farm substation.

What Happened

The incident occurred during maintenance work at an electrical substation within a wind farm near Inverness. A worker had been sent to carry out planned maintenance activities when an electrical flashover occurred.

The worker sustained serious, life-changing injuries that have required multiple surgical procedures.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the incident followed a departure from the prepared electrical switching programme. As a result, maintenance work was carried out on one electrical cabinet while an adjacent cabinet remained live, allowing part of the electrical system to remain energised during the work.

The HSE investigation concluded that if the original switching programme had been followed correctly, the incident would not have occurred. It also found that the company did not have a suitable system in place to check or review switching programmes to ensure procedures were being followed at all times, nor a formal process to approve changes to those programmes.

The Outcome

The company pleaded guilty to breaching Sections 3(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. It was fined £80,000,

Additional Context

Electrical maintenance work carries a high risk of serious injury if systems are not properly isolated. Robust procedures are essential to ensure that electrical equipment is made dead, remains isolated, and that any deviations from planned work are formally reviewed and authorised.

More Information

Free guidance for employers on electrical safety and managing health and safety is available on the HSE website at: https://www.hse.gov.uk/pubns/priced/hsr25.pdf

Worker suffers lifechanging injuries after fall from scaffolding

Summary

Two construction companies have been fined after a worker fell from scaffolding during an unplanned lifting operation, suffering life-changing injuries.

What Happened

The incident occurred during refurbishment works at a site in London. A general labourer was involved in an unplanned lifting operation when a load became trapped. As the worker attempted to free the load, it suddenly released, pulling him over the edge of the scaffold.

The worker fell from height and sustained serious, lifechanging injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the contractor carrying out the work had failed to adequately plan, manage and monitor the task. In particular, routine lifting operations had not been properly assessed and appropriate lifting equipment and accessories were not being used.

The HSE also identified failings by the principal contractor, which had not properly managed or monitored the work being undertaken on site. The investigation found that insufficient detail within lifting plans was not recognised, and the use of untested lifting accessories was not adequately challenged or prevented.

The Outcome

The principal contractor pleaded guilty to breaching Regulation 13(1) of the Construction (Design and Management)
Regulations 2015 and was fined £640,000. The company was also ordered to pay £4,787.59 in costs and a £2,000 victim surcharge.

The contractor carrying out the work pleaded guilty to breaching Regulation 15(2) of the Construction (Design and Management) Regulations 2015. It was fined £160,000 and ordered to pay £4,787.59 in costs and a £2,000 victim surcharge.

Additional Context

HSE guidance states that contractors must plan, manage and monitor construction work under their control to ensure risks to health and safety are properly controlled.

The level of planning and supervision should be proportionate to the size, complexity and risk profile of the project, particularly where lifting operations and work at height are involved.





More Information

Further guidance on managing health and safety in construction, including duties under the Construction (Design and Management) Regulations 2015, is available on the HSE website at: https://www.hse.gov.uk/pubns/priced/l153.pdf



COP30 in Belém: what was agreed — and what fell short

The 2025 UN climate summit, COP30, took place from 10–21 November in Belém, Pará, Brazil. It was the first time a Conference of the Parties has been hosted in the Amazon region.



Key Decisions and Focus Areas

- Tripling climate-adaptation finance: Delegates agreed on a major boost to support for vulnerable communities worldwide, setting a new target to triple funding for adaptation measures.
- New emphasis on implementation and transformation: COP30 reaffirmed the commitment to the Paris Agreement and marked a shift from decades of negotiation toward what supporters described as a new phase of economic, social and ecological transformation.
- Nature, land, forests, and Indigenous rights: The
 conference placed strong focus on forests, land,
 biodiversity, Indigenous peoples and local communities.
 Some US\$1.8 billion was pledged for land rights and nature
 -based initiatives; Brazil announced new Indigenous
 territories.
- Discussions on trade, finance and low-carbon investment:
 For the first time, COP talks included more serious conversations about how trade policy and financial flows can support climate action and sustainable development globally.

What COP30 Failed to Deliver

- No roadmap to phase out fossil fuels: A proposed formal roadmap for phasing out fossil fuels was blocked. More than 80 countries had supported it, but opposition from major fossil-fuel producing nations led to its exclusion from the final agreement. Instead, the pact was downgraded to voluntary diplomatic commitments.
- Insufficient emissions-cutting pledges: Despite nearly 200
 parties attending, many failed to submit robust new
 emissions targets. Scientists warn that current national
 commitments remain weak and the world is still heading
 toward a dangerous warming pathway possibly 2.6 °C by
 2100.

 Criticism for lack of ambition: Observers say COP30 offered only a "minimal basis" for climate action, not the bold step many had hoped for. The conference exposed deep divisions among countries over finance, fossil fuels and climate justice, raising doubts about collective political will.

What Leaders and Experts Are Saying

Ántónio Guterres, Secretary-General of the United Nations, described COP30 as a signal that global cooperation remains alive — but warned that "the gap between where we are and what science demands remains dangerously wide." He urged countries to deepen emission cuts, accelerate transitions from fossil fuels to clean energy, and prioritise investments in renewables and nature.

What Happens Next

With COP30 concluded, much now depends on follow-through. The pledges for increased adaptation funding and support for nature and Indigenous lands must now be translated into concrete investment and action. But without a clear fossil-fuel phase-out or robust emissions-cutting commitments, scientists warn global warming could remain on a trajectory far beyond the 1.5 °C goal of the Paris Agreement — leaving countries to rely heavily on adaptation and resilience measures.

Negotiators and civil society alike emphasise that COP30 may be seen as a turning point in tone — with more focus on implementation, equity and nature — but that the next few years will be decisive to see if this translates into real-world impact.

More information

See: https://cop30.br/en

Tribunal ruling on changing room dispute

Overview

A nurse who objected to sharing a women's changing room with a transgender doctor has succeeded in part of her legal challenge against NHS Fife. An employment tribunal upheld her complaint of harassment but dismissed her wider claims of discrimination and victimisation, along with all allegations made against the doctor involved.

Background

The case centred on events at Victoria Hospital in Kirkcaldy. The nurse, who has worked for the NHS for three decades, raised concerns in early 2024 about sharing a female changing room with a transgender colleague. Following her complaint, she was suspended and later pursued legal action under the Equality Act 2010, arguing she had been subjected to harassment, discrimination, and victimisation by NHS Fife and by the doctor concerned.

The tribunal, a high-profile and highly scrutinised hearing, examined the circumstances surrounding the complaint and NHS Fife's subsequent actions.

Tribunal Findings

The judgement identified four specific ways in which NHS Fife had harassed the nurse:

• Failure to act on her initial concern: The tribunal ruled that when she raised her objection, the employer should have suspended permission for the doctor to use the women's changing room until new rotas meant they would no longer overlap.

- Prolonged investigation: The time taken to investigate allegations against the nurse was deemed unreasonable.
- Restrictions on discussion: Instructions not to talk about the case were found to be inappropriate.
- Reference to unproven concerns: The health board's mention of unsubstantiated claims that she had put patients at risk was considered a form of harassment.

However, the tribunal dismissed claims of discrimination and victimisation against NHS Fife, and it dismissed all claims against the doctor. A separate hearing will determine any remedy or compensation.

Reactions

The legal representatives issued a cautious initial response, saying parts of the judgement appeared "problematic" but holding off on detailed comment due to the judgement's length.

NHS Fife stated it respected the tribunal's careful consideration, emphasising that the majority of allegations were dismissed but confirming it would review the findings in detail with its legal advisers.

Scotland's first minister described the ruling as important in a complex area, noting the need for both NHS Fife and the Scottish government to consider any wider implications. He also underlined that employees are entitled to raise concerns about workplace matters within the law.

Wider Commentary

The case has attracted national attention, touching on the contentious debate around single-sex spaces and transgender inclusion. Advocacy groups responded from differing perspectives:

One campaign group supporting the nurse expressed disappointment in the tribunal's approach, arguing that it had not provided employers with clarity on managing single-sex facilities.

A discrimination lawyer working with a trans-led organisation welcomed the ruling, describing it as balanced and noting the tribunal had also concluded that the nurse had harassed the doctor. She stressed that the judgement recognised rights on both sides and the need for employers to accommodate differing needs sensitively.

Political and Legal Context

The dispute unfolded against the backdrop of ongoing national debate in Scotland regarding gender identity, single-sex spaces, and equality law. The timing of the Supreme Court's ruling on the definition of sex in equality legislation heightened the political interest surrounding the case.

Despite expectations that the Supreme Court judgement might decisively influence the outcome, the tribunal ruled more narrowly. It concluded that the definition of sex in law does not make it automatically lawful or unlawful for a trans woman to use a female changing room at work; instead, decisions depend on the specific circumstances and how employers manage them.

What This Means

The tribunal's ruling focuses on how NHS Fife handled a workplace concern rather than making a broader statement on who may access single-sex spaces. As a result, the decision has not delivered the clarity some hoped for and may prompt further discussion about workplace policies, staff welfare, and the balance of rights. A future remedies hearing will determine what compensation, if any, the nurse will receive.

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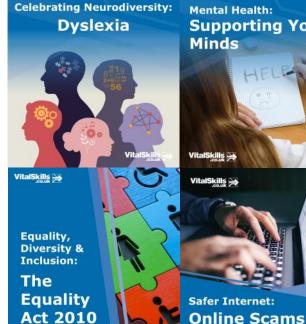


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