Lorry driver suffered life-changing injuries after fall from trailer

Summary

A visiting lorry driver sustained severe injuries after falling from a trailer during loading activities at a manufacturing site.

What Happened

The incident occurred on 18 November 2024 at a site in County Durham. A Class 1 driver, visiting to deliver and collect goods, was manually moving cages on and off a cage carrier as part of the loading process.

When a wheel on one of the cages became stuck, the cage toppled. The driver stepped back to avoid it and fell from the trailer. They suffered a brain injury and multiple fractures and have been unable to return to work since.

The Investigation

The Health and Safety Executive (HSE) found that adequate arrangements had not been put in place to protect both employees and visiting drivers from falls during loading and unloading tasks. Suitable and sufficient measures to prevent falls from height were lacking.

HSE defines work at height as any activity carried out in a place where, without precautions, a person could fall far enough to cause injury. Guidance on working at height, along with step-by-step advice, is available via the HSE website.

HSE's workplace transport safety guidance also sets out what organisations must do to manage risks from vehicle and loading operations. Applying this guidance would have highlighted the hazards associated with the loading method used and shown that the risk could have been eliminated by altering how the work was carried out.

The Outcome

The organisation admitted breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £80,000 and ordered to pay £4,537.32 in costs.

Additional Context

Falls from vehicles remain a common cause of serious workplace injuries. Effective planning, safer systems of work, and appropriate equipment can significantly reduce such risks.

More Information

Working at Height Regulations guidance is available at:
https://www.hse.gov.uk/work-at-height/

Workplace transport safety guidance is available at:
https://www.hse.gov.uk/workplacetransport/index.htm

Personal Learning and Development Planning: A Practical Guide

Summary

January is an ideal time to pause, reflect, and take a deliberate approach to your professional development. A Personal Learning and Development Plan (PLDP) provides a simple structure for doing exactly that — helping you focus on meaningful improvement rather than defaulting to courses or qualifications that feel useful but lack clear purpose.

We have produced some guidance to support a thoughtful, realistic approach to development.

Start With Purpose, Not Activities

It begins by encouraging you to start with purpose. Effective development plans focus on outcomes — what you want to be better at, more confident in, or able to do differently over the next 6–12 months — rather than jumping straight to activities. Training may support development, but it is never the goal in itself.

Take an Honest Snapshot of Where You Are Now

A strong plan is grounded in an honest snapshot of where you are now. This means reflecting on your strengths, areas of hesitation, recent feedback, and situations that stretch or drain you. This is not about self-criticism, but about understanding your starting point so progress can be planned realistically.

Choose a Small Number of Meaningful Goals

Rather than trying to change everything at once, the guidance recommends choosing a small number of meaningful goals — typically three to five. Applying the SMART framework helps ensure these goals are clear, achievable, and genuinely relevant to your role or future direction.

Think Broadly About How Learning Happens

The guidance also encourages you to think broadly about how learning happens. Much of the most effective development takes place through practice, stretch opportunities, observation, coaching, feedback, and reflection — not just formal training. Learning is most effective when it is applied regularly in real work.

Be Realistic About Time & Constraints

Being realistic about time and constraints is another key theme. Even well-intentioned plans can fail if they ignore workload pressures and competing priorities.

Be Clear About What Progress Looks Like

Small, consistent actions are far more effective than ambitious plans that never quite happen.

Review, Reflect & Adjust

Finally, the guidance emphasises the importance of review. A development plan should be revisited regularly, with progress reflected on and adjustments made where needed. Changing your plan is not a sign of failure — it is a sign that learning is taking place.

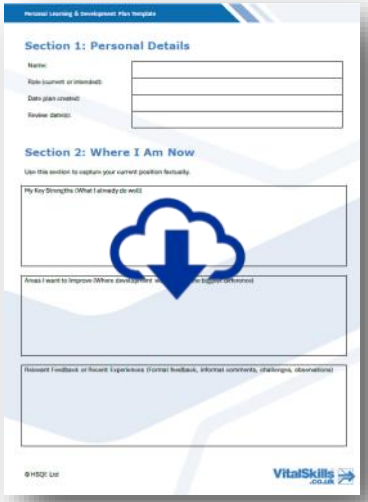
Together, these principles help turn development from a once-a-year exercise into an ongoing, practical process that supports real growth and confidence over time.

More Information

Download the Personal Learning and Development Plan Guidance and Template.

Personal Learning and Development Plan Guidance

Personal Learning and Development Plan Template



Apprentice injured after falling through fragile roof

Summary

Two companies have been fined following an incident in which an apprentice fell from height while carrying out work on a fragile roof during the installation of CCTV at a commercial site.

What Happened

The incident occurred at a commercial industrial estate in Weymouth while an electrical apprentice was working on the roof of a lean-to structure attached to a warehouse. The work involved installing electrical cables and conduit around the perimeter of the building in preparation for CCTV installation. The apprentice was using a makeshift crawling board when he fell approximately 11 feet through the fragile roof onto the concrete floor below. He lost consciousness and was unable to feel his body before the arrival of the emergency services. He was temporarily unable to walk and sustained back injuries, including muscular tissue damage, requiring ongoing physiotherapy.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the employer had failed to properly plan the work at height and had not provided suitable equipment to prevent a fall through the fragile roof. The HSE concluded that the apprentice should not have been working on the fragile roof where this could have been avoided.

The investigation identified that suitable control measures, such as edge protection, roof coverings, stagings or similar collective protection systems, had not been put in place. Where work on fragile roofs cannot be avoided, such measures are essential to prevent falls, with personal fall protection used where necessary.

The HSE also took enforcement action against a second company involved in the project after it failed to comply with a legal requirement to produce documents to support the HSE's criminal investigation.

The Outcome

One company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and was fined £16,000, with £4,168 in costs.

The second company pleaded guilty to breaching Regulation 20(2)(k) of the Health and Safety at Work etc. Act 1974 after failing to provide documents requested by the HSE. It was fined £6,000 and ordered to pay £1,200 in costs.

Additional Context

Working at height remains one of the leading causes of serious workplace injury and fatalities. Employers must ensure that work at height is properly planned, appropriately supervised and carried out safely, including the selection of suitable work equipment. Suitable and sufficient measures must be taken to prevent falls liable to cause personal injury.

More Information

The HSE provides detailed guidance on working safely at height, including managing fragile surfaces and selecting appropriate fall prevention measures, available on the HSE website.

Supervisor seriously injured after foot caught in rotating auger

Summary

A worker suffered severe injuries, losing part of his foot, after it became trapped in moving machinery at an animal feed site.

What Happened

The incident occurred on 14 November 2023 at a mill in York, where a 41-year-old supervisor was attempting to deal with a maintenance problem on a feed press. He was able to open the machine while its components were still running at speed, allowing his foot to become caught in a rotating auger – a device that uses a central shaft with a coiled blade to move excess feed. He sustained life-changing injuries and required a six-week stay in hospital.

The Investigation

The Health and Safety Executive (HSE) found that access to dangerous parts of the machinery had not been adequately prevented. Investigators also identified a lack of a suitable and sufficient risk assessment for the work taking place.

The HSE emphasises that employers must ensure effective safeguards are in place to stop workers coming into contact with hazardous moving parts. Fixed guards are usually required; where frequent access is necessary, interlocked guards should be used to stop movement before any person can reach the danger area.

The Outcome

The company admitted breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It received a £500,000 fine and was ordered to pay £4,455 in costs.

More Information

Detailed guidance on preventing access to dangerous machinery is available through the HSE's Provision and Use of Work Equipment Regulations 1998 (PUWER) resources, which set out the legal requirements for work equipment safety: https://www.hse.gov.uk/work-equipment-machinery/puwer.htm

Worker fell through fragile skylight during roof repairs

Summary

A construction company has been fined £80,000 after a sub-contractor fell more than 15 feet through a fragile skylight while carrying out roof repair work at an industrial site in Hampshire.

What Happened

In January 2024, a 29-year-old sub-contractor was working on roof repairs at an industrial estate in Titchfield. He fell through a fragile skylight and landed on the solid floor below. The fall resulted in multiple fractures, leaving him unable to work for several months and with lasting mobility issues affecting one leg.

The roof repair project had begun in December 2023 but was progressing slowly. To accelerate completion, additional workers were brought in to work over a weekend in mid-January, including the injured sub-contractor.

The Investigation

The Health and Safety Executive found that no scaffolding had been installed at the open edges of the roof and that inadequate measures were in place to prevent or mitigate falls through fragile areas. There was nothing to prevent the worker from falling through the skylight or to reduce the consequences of a fall.

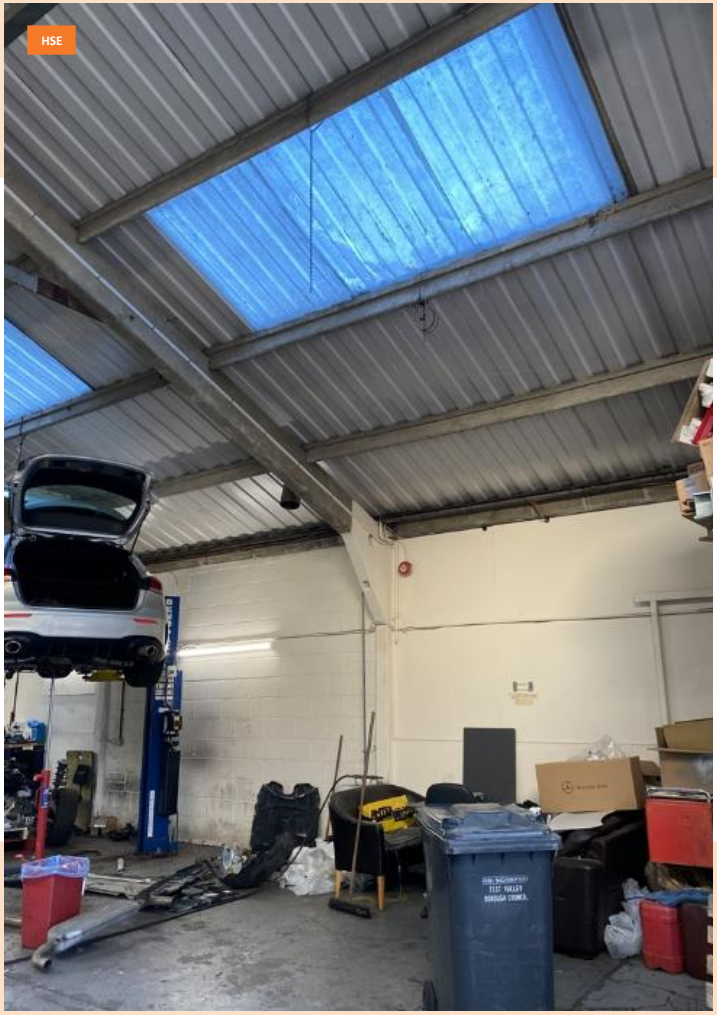
Despite the seriousness of the incident, the company and remaining sub-contractors returned to the site the following day and continued work without implementing any additional safety controls.

The Outcome

The company pleaded guilty to breaching the Work at Height Regulations 2005 (Regulation 6(3)) and was fined £80,000. It was also ordered to pay costs of £2,630. The company director, who had been present during the works, pleaded guilty under section 37(1) of the Health and Safety at Work etc. Act 1974. He received a three-month prison sentence, suspended for 12 months, and was ordered to pay £2,630 in costs.

Key Learning Points

- Fragile roofs and skylights must be treated as high-risk areas. Falls through fragile materials are a well-known hazard. Suitable controls such as coverings, guardrails, safety nets, or working platforms must be in place before work starts.
- Working at height requires proper planning and suitable controls. Scaffolding, edge protection, and fall-prevention measures should be selected using the hierarchy of control, prioritising collective protection over personal measures.
- Time pressure must never override safety. Accelerating work or bringing in additional workers increases risk if controls are not reviewed and adapted. Changes to workforce or programme require a reassessment of hazards.
- Serious incidents must trigger immediate review and corrective action. Continuing work after a major fall without introducing additional safety measures exposes workers to further risk and significantly worsens enforcement outcomes.
- Directors and managers can be held personally accountable. Where senior leaders are aware of unsafe practices and fail to intervene, they may face prosecution alongside the organisation.



More Information

More information about work at height can be accessed at: https://www.hse.gov.uk/work-at-height/index.htm and Health and safety in roof work can be accessed at: https://www.hse.gov.uk/pubns/priced/hsg33.pdf

Worker suffered life-changing hand injuries in machinery incident

Summary

A metal polishing company in the West Midlands has been fined after an employee suffered severe hand injuries, including the amputation of a finger, when his hand became entangled in an unguarded tube polishing machine.

What Happened

On 8 July 2024, an employee was loading a tube polishing machine at a metal polishing premises in Oldbury. The machine had faulty rollers, which required manual intervention to straighten metal tubes during operation.

While leaning over the machine to correct the alignment of the tubes, the employee's left hand became caught in the machine's unguarded rotating cogs and chains.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to prevent access to dangerous moving parts of the machinery. The rotating cogs and chains were unguarded, exposing workers to a foreseeable risk of entanglement.

The investigation identified that the machine did not meet basic safety standards and that effective guarding had not been installed or maintained, despite clear legal requirements and long-standing guidance on machinery safety.

The Outcome

The company pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998. It was fined £24,000 and ordered to pay a £2,000 victim surcharge and £4,073.10 in costs.

Additional Context

The injured worker suffered the amputation of his ring finger to the first knuckle, crushing injuries to two other fingers, and has undergone eight operations to date, with further surgery required. He has been unable to return to work since the incident. HSE guidance is clear that the primary method of preventing access to dangerous parts of machinery is the use of fixed guards that are securely attached and not easily removed. Where risks remain, additional protective measures must be implemented.

The HSE inspector stated that the incident was entirely preventable and highlighted that failures in machinery guarding continue to cause serious and life-changing injuries across industry.

Key Learning Points

- Dangerous parts of machinery must be effectively guarded to prevent access at all times.
- Faulty equipment should not be used as a justification for unsafe manual intervention.
- Fixed guards should be the first line of defence against entanglement risks.
- Machinery safety standards must be maintained throughout the life of the equipment, not just at installation.
- Failure to comply with long-established guidance can result in serious injury and significant enforcement action.

More Information

The Safe use of work equipment, Provision and Use of Work Equipment Regulations 1998, Approved Code of Practice and guidance (L22) can be accessed at:
https://www.hse.gov.uk/pubns/priced/l22.pdf

Engineering firm fined after failing to control exposure to metalworking fluids

Summary

An engineering firm in Bedfordshire has been fined £27,200 after failing to adequately manage the risks associated with metalworking fluids, placing employees at risk of ill-health including dermatitis, asthma and other respiratory conditions.

What Happened

The issues were identified during a routine inspection carried out by the Health and Safety Executive (HSE) in July 2022. Inspectors raised concerns about the use and management of metalworking fluids in CNC machining processes.

The inspection highlighted shortcomings in how the risks from metalworking fluids were being assessed and controlled, particularly in relation to employee exposure to fluid mist and skin contact.

The Investigation

Following the inspection, HSE served formal Improvement Notices requiring the company to:

- Carry out suitable and sufficient risk assessments for activities involving metalworking fluids
- Put appropriate testing and monitoring arrangements in place

A follow-up inspection found that the company had failed to comply with these notices. Risk assessment documentation remained inadequate, failing to:

- Properly identify hazards and potential health effects
- Consider measures to reduce the risk of inhalation of metalworking fluid mist
- Address the maintenance of metalworking fluid quality

Inspectors also found that fluid testing was still being carried out less frequently than recommended in HSE guidance. Due to continued non-compliance, a prosecution was initiated in January 2024.

The Outcome

The company pleaded guilty to breaching Regulation 6 of the Control of Substances Hazardous to Health Regulations and to two charges of breaching Section 21 of the Health and Safety at Work etc. Act 1974. The firm was fined £27,200 and ordered to pay £30,000 in costs.

Additional Context

HSE guidance makes clear that employers using metalworking fluids must:

- Maintain fluid quality and control bacterial contamination
- Minimise skin contact with fluids
- Prevent or adequately control airborne mist
- Carry out appropriate health surveillance where exposure is likely

Failure to manage these risks can result in long-term occupational ill-health, even where no immediate injuries are apparent.

Key Learning Points

- Health risks from metalworking fluids include dermatitis, asthma and other serious respiratory conditions
- Risk assessments must clearly identify health hazards and set out effective control measures
- Metalworking fluid quality must be actively monitored and maintained
- Exposure to mist and skin contact must be minimised through engineering and procedural controls
- Improvement Notices must be fully complied with — failure to do so can lead directly to prosecution

More Information

Further guidance on metalworking fluids is available on the HSE website at:
https://www.hse.gov.uk/metalworking/index.htm

Apprentice pulled into machinery during training

Summary

A manufacturing company has been fined £187,600 after an apprentice suffered serious injuries when his clothing became entangled in a radial-arm drill.

What Happened

An 18-year-old apprentice machinist was injured on 10 July 2023 while operating a radial-arm drill at a manufacturing site in Newbury. He had been employed for less than a year and was still learning how to use the various machines involved in the production of industrial valves and filters.

During the operation, the apprentice's shirt became caught in the rotating parts of the drill, pulling him into the machine. He sustained three broken ribs and suffered severe injuries to his chest.

The Investigation

An investigation by the Health and Safety Executive (HSE) found multiple serious failings in the management of machinery safety.

The radial-arm drill involved did not have adequate guarding to prevent access to dangerous moving parts. Machine operators, including the injured apprentice, had not received sufficient training on the machine's safety features or safe operating procedures.

The investigation also identified that the machine had been modified by the company in a way that increased the risk of operators becoming caught and pulled into the equipment. HSE guidance makes clear that employers must assess risks and put effective controls in place to prevent access to dangerous parts of machinery. This is normally achieved using fixed or adjustable guards, or where this is not reasonably practicable, other protective devices that stop dangerous movement. Employers must also ensure workers receive suitable information, instruction, training, and supervision.

The Outcome

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

At a hearing on 8 December 2025, the company was fined £187,600 and ordered to pay £7,464 in costs.

Additional Context

The apprentice was hospitalised for five days, required skin grafts, and was unable to work for six months. A large area of skin was removed from his chest, leaving him with permanent scarring and loss of sensation.

He has since said that he would never wish to operate a radial-arm drill again due to the trauma and lasting impact of the incident.

Key Learning Points

- Machinery must be adequately guarded to prevent access to dangerous moving parts at all times.
- Young and inexperienced workers require enhanced supervision, particularly during training periods.
- Modifying machinery without proper risk assessment can significantly increase the likelihood of serious injury.
- Training must include not only how to operate machinery, but how to use safety features effectively.
- Serious, life-changing injuries are often entirely preventable through basic machinery safety controls and robust supervision.

More Information

Further guidance on controlling risks in engineering environments can be found at:
https://www.hse.gov.uk/pubns/books/hsg129.htm

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Worker suffered life-changing injuries after machinery incident

Summary

A wood manufacturing company has been fined £160,000 after an employee sustained life-changing injuries while attempting to clear a jammed log from machinery at a sawmill.

What Happened

In May 2021, a 37-year-old employee was clearing a jammed log on a quad saw machine. The worker climbed onto a stationary conveyor bed and used a metal pole to dislodge the obstruction. While he was on the conveyor, it unexpectedly started to move, dragging his legs across moving chains and trapping them against a stop plate.

As a result of the incident, the employee's right leg was amputated below the knee, and he also suffered significant injuries to his left leg.

The Investigation

An investigation by the Health and Safety Executive found that the company had failed to adequately assess the risks associated with clearing jams on the quad saw machine.

Effective measures had not been devised or implemented to prevent access to dangerous moving parts, nor to ensure that the machine was fully immobilised before anyone entered the danger zone.

The investigation also identified failures to provide a safe system of work, along with inadequate information, instruction, training and supervision for employees operating the machinery.

The Outcome

The company pleaded guilty to breaching section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £160,000 and ordered to pay costs of £7,395.51 at a magistrates' court hearing in December.

Additional Context

Although health and safety standards in the sawmilling industry have improved in recent years, it remains a high-risk sector. The rate of major injuries is more than two and a half times higher than in general manufacturing. Machinery-related incidents continue to be a significant cause of serious injury, with failures around lock-out and isolation procedures remaining a common issue. On average, the industry experiences around one fatality each year.

Key Learning Points

- Jam-clearing and maintenance tasks must be fully risk assessed, with clear controls to prevent access to dangerous moving parts.
- Machinery must be properly isolated and locked off before anyone enters a danger zone or attempts to clear obstructions.
- Safe systems of work should be clearly defined, documented and consistently followed.
- Employees must receive suitable and sufficient information, instruction, training and supervision for machinery operations.
- High-risk industries should not rely on experience or informal practices; robust controls and procedures are essential to prevent life-changing injuries.

More Information

See: https://www.hse.gov.uk/pubns/books/hsg172.htm

Worker fell more than 30 feet from MEWP

Summary

An arboriculture company has been fined after an employee suffered life-altering back injuries when he fell more than 30 feet from the basket of a mobile elevating work platform (MEWP) during tree surgery work.

What Happened

An employee was carrying out tree surgery from the basket of a MEWP at a mobile site in Derby on 25 January 2024. While the platform was elevated, the MEWP stopped working. There was no one on site who was able to safely lower the basket to the ground.

With no rescue plan in place, the employee attempted to abseil from the basket. He fell to the ground from a height of over 30 feet, sustaining serious and life-altering back injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the work at height had not been properly planned, supervised, or carried out safely. In particular, the company had failed to:

- Complete a suitable and sufficient risk assessment for work at height activities
- Ensure employees were appropriately trained in the use of lifting equipment
- Put in place an effective rescue plan for MEWP operations

The HSE also identified that poor decision-making on site directly contributed to the incident.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £20,000 and ordered to pay £6,956 in costs.

A director also pleaded guilty to breaching Section 37(1) of the Health and Safety at Work etc. Act 1974. He was fined £1,000 and ordered to pay £400 in costs.

Additional Context

The Work at Height Regulations require employers to ensure that work at height is properly planned, appropriately supervised, and carried out in a safe manner.

Where lifting equipment such as MEWPs is used, HSE guidance states that:

- Operators must receive suitable training
- Emergency and rescue arrangements must be planned in advance
- Appropriate equipment and competent personnel must be available on site

Key Learning Points

- Work at height must be properly planned – suitable and sufficient risk assessments are essential.
- Rescue planning is critical – MEWP operations must include clear, rehearsed emergency arrangements.
- Training matters – operators must be competent in both normal operation and emergency procedures.
- Do not rely on improvised solutions – attempting self-rescue without planning can significantly increase the risk of serious injury.
- Directors and supervisors can be held personally accountable when their decisions contribute to unsafe work.

More Information

More information about the safe use of lifting equipment can be accessed at:
https://www.hse.gov.uk/pubns/books/l113.htm

Workers diagnosed with HAVS after prolonged vibration exposure

Summary

A social housing provider has been fined £32,000 after more than ten workers were diagnosed with vibration-related ill-health, including Hand-Arm Vibration Syndrome (HAVS), following long-term use of vibrating tools.

What Happened

HSE began investigating after receiving a series of reports of vibration-related ill-health from workers employed across a range of trades, including bricklayers, joiners, electricians, plasterers and caretakers. Their day-to-day activities involved frequent use of high-vibration tools such as drills, impact drivers, vibrating plates and road breakers.

Over time, many workers developed symptoms consistent with HAVS and other vibration disorders linked to prolonged exposure.

The Investigation

HSE found that employees had been regularly exposed to vibration without adequate protection or oversight. Shortcomings identified included:

- No suitable or sufficient vibration risk assessments.
- Poor control measures, such as failing to remove or substitute vibrating tools, or limit exposure duration.
- Inadequate tool maintenance, increasing vibration levels.
- Weak or absent health surveillance, meaning early signs of ill-health were not detected.
- Insufficient training on the risks linked to vibrating equipment.

HAVS can cause permanent damage to nerves, blood vessels, joints and muscles in the hands and arms. Symptoms include pain, tingling, numbness and reduced grip strength, severely affecting daily activities.

The Outcome

The organisation pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £32,000 and ordered to pay £6,226 in costs.

HAVS is one of the most prevalent occupational health issues associated with the long-term use of vibrating tools. Employers must carry out appropriate risk assessments, put effective controls in place, maintain equipment properly, train workers on the risks and ensure robust health surveillance.

Key Learning Points

- Vibration risks must be properly assessed – Employers are required to carry out suitable and sufficient vibration risk assessments for all tasks involving vibrating tools, taking account of exposure levels, duration and frequency.
- Exposure should be eliminated or reduced so far as reasonably practicable – This includes selecting lower-vibration tools, substituting processes, limiting trigger time, rotating tasks and planning work to avoid prolonged exposure.
- Poorly maintained tools increase risk – Inadequate maintenance can significantly raise vibration levels. Regular inspection, servicing and timely replacement of tools are essential control measures.
- Health surveillance is critical for early detection – Robust health surveillance arrangements are needed to identify early symptoms of HAVS before permanent damage occurs. Failing to act early can result in irreversible injury.
- Workers must be trained and informed – Employees need clear training on vibration risks, symptoms of HAVS, safe use of equipment and the importance of reporting early signs of ill-health.
- HAVS can be life-changing and permanent – Symptoms such as numbness, pain and reduced grip strength can severely affect both work and everyday activities, underlining the importance of prevention rather than reaction.
- Repeated failures attract enforcement action – Long-term exposure without adequate controls demonstrates systemic management failings and can result in prosecution, fines and reputational damage.

More Information

HSE guidance on managing vibration risks:
https://www.hse.gov.uk/vibration/hav/index.htm

Hand-arm vibration – The Control of Vibration at Work Regulations 2005 (L140):
https://www.hse.gov.uk/pubns/priced/l140.pdf

Worker suffered leg amputation after sheet metal crush injury

Summary

A manufacturing company has been fined after an employee suffered life-changing injuries, including the amputation of his lower leg, when heavy metal sheets fell on him at a factory on the Isle of Wight.

What Happened

The incident occurred while a worker was moving a trolley loaded with approximately 30 pieces of sheet metal, each weighing more than 20kg. As the trolley was being moved through the factory, it toppled over, causing the stacked metal sheets to fall onto the worker's legs. The worker sustained severe crush injuries and later required the amputation of his lower right leg.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the task was not being carried out safely. The trolley being used was not suitable for transporting heavy sheet metal, routes for moving trolleys around the factory were unclear, and employees had not received adequate training in the safe movement of heavy materials.

The HSE also identified that a similar incident had occurred almost two years earlier. Despite this, the risks associated with moving heavy sheet metal had still not been adequately assessed, and no safe system of work had been implemented. The investigation concluded that appropriate action following the earlier incident could have prevented this life-changing injury.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £200,000 and ordered to pay £9,056 in prosecution costs.

Key Learning Points

- Work equipment must be suitable for the task – Trolleys and handling equipment should be specifically designed for the type, size and weight of loads being moved. Using unsuitable equipment significantly increases the risk of instability and collapse.

- Manual handling and transport risks must be properly assessed – Tasks involving heavy or stacked materials require suitable and sufficient risk assessments that consider load stability, centre of gravity, routes and foreseeable loss of control.
- Safe systems of work are essential – Procedures should be in place for moving heavy materials, including load limits, stacking methods, defined routes and rules for supervision.
- Routes must be planned and kept clear – Transport routes within factories should be clearly defined, suitable for the equipment in use and free from obstructions that could cause loss of control or overturning.
- Training must match the risk – Workers must be trained in safe handling techniques, use of trolleys and equipment, and what to do if a load becomes unstable.
- Near-misses and previous incidents must drive change – A similar earlier incident was a clear warning. Failure to act on lessons learned demonstrates serious management failings and exposes workers to repeated risk.
- Severe injuries are often foreseeable and preventable – Crush injuries from falling loads can result in permanent, life-changing harm, reinforcing the need for effective planning, equipment selection and supervision.
- Failings at management level carry serious consequences – Repeated shortcomings in risk assessment and control can lead to prosecution, substantial fines and lasting reputational damage.

More Information

Further guidance on the safe use of work equipment, including the Provision and Use of Work Equipment Regulations 1998 (PUWER), is available on the HSE website at: https://www.hse.gov.uk/work-equipment-machinery/puwer.htm

Unregistered gas work led to sentencing in Cheshire

Summary

An unregistered gas installer and his father have been sentenced after carrying out illegal gas work at two domestic properties in Cheshire, placing householders at risk of serious harm.

What Happened

In April 2022 and December 2022, an unregistered individual carried out new boiler installations at two homes in Northwich despite not being registered with the Gas Safe Register.
On one occasion, his father – a registered gas engineer – signed off and commissioned the boiler without attending the property or checking the installation for safety.

The Investigation

Following a complaint from a homeowner, the Health and Safety Executive worked with the Gas Safe Register to investigate. An inspection by a qualified engineer identified defects that resulted in the boiler being classed as at risk and dangerous.

Defects included inadequate support for the chimney and flue system, creating a risk of carbon monoxide poisoning. The investigation confirmed that gas work had been undertaken illegally and that safety checks had been knowingly bypassed.

The Outcome

The unregistered installer pleaded guilty to breaching Regulation 3(3) of the Gas Safety (Installation and Use) Regulations 1998. They were sentenced to serve a 12-month community order, 200 hours of unpaid work, pay costs of £2,500 and a compensation payment of £1,460 to an affected homeowner

His father pleaded guilty to breaching section 3(2) of the Health and Safety at Work etc. Act 1974. He was sentenced to serve a 12-month community order, 200 hours of unpaid work, and costs of £2,500.

Additional Context

The HSE highlighted that carrying out gas work without appropriate registration is illegal and potentially life-threatening. Unsafe installations can lead to gas leaks, fires, explosions, and carbon monoxide poisoning.

Key Learning Points

- Gas work must only be carried out by engineers registered with the Gas Safe Register.
- Registered engineers must never sign off or commission work they have not personally inspected and tested.
- Bypassing gas safety requirements can expose householders to catastrophic risks, including carbon monoxide poisoning.
- Consumers should always verify an engineer's registration and identification before allowing gas work to proceed.

More information

Gas engineers and consumers can contact the Gas Safe Register in any of these ways:

Website: https://www.gassaferegister.co.uk/

Phone – Consumers: 0800 408 5500; Engineers: 0800 408 5577

Email – enquiries@gassaferegister.co.uk

Steel-fixer seriously injured after blockwork wall collapse

Summary

A construction company has been fined £100,000 after a steel-fixer sustained life-changing injuries when a newly built blockwork wall collapsed during excavation works in Poole.

What Happened

The incident occurred on 19 August 2022 at a construction site on Old Coast Guard's Road, Poole. A blockwork wall had been constructed at the edge of a deep excavation and was backfilled before the mortar had properly set.

At around 8.30am, three workers, including a 69-year-old steel-fixer, began work at the lower level of the excavation. While they were working nearby, the wall at the north end of the excavation collapsed without warning, crushing the worker against the concrete floor.

Emergency services attended the scene. However, there was no emergency rescue plan in place. Access to the excavation relied on an unstable ladder, delaying rescue efforts. The injured worker had to be hoisted out by the fire and rescue service before being airlifted to hospital, where he was treated for life-changing injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to properly assess and manage foreseeable risks associated with temporary works. There was no temporary works design for the blockwork wall or for other temporary structures on site. The company had not appointed a Temporary Works Co-ordinator or Temporary Works Supervisor, despite this being highlighted as a serious concern in a safety report issued just eight days before the incident.

Without a temporary works procedure in place, groundworkers backfilled the wall prematurely, directly leading to its collapse.

The Outcome

The company pleaded guilty to breaching Regulations 13(1) and 19(1) of the Construction (Design and Management) Regulations 2015. It was fined £100,000 and ordered to pay £8,242 in costs and a £2,000 victim surcharge.

Additional Context

Temporary works on construction sites include excavations, trenches, temporary slopes and stockpiles, formwork, falsework, propping, shoring, edge protection, scaffolding, site fencing and signage.

Following the hearing, an HSE inspector emphasised that the correct design and execution of temporary works is an essential element of risk prevention in construction. The failure to act on advice from the company's own health and safety consultants was described as making the incident wholly avoidable.

Key Learning Points

- Temporary works must be formally designed, assessed and controlled before loading or backfilling takes place.
- Mortar and construction materials must be allowed sufficient time to gain strength before being subjected to load.
- Competent Temporary Works Co-ordinators and Supervisors should be appointed where temporary works are present.
- Safety advice and warnings must be acted upon immediately, particularly where serious risks have been identified.
- Excavations must have safe access and a clear emergency rescue plan in place.
- Poor planning and management of temporary works can result in life-changing injuries, prosecution and significant financial penalties.

More Information

Guidance on the management of temporary works is available on the HSE website at: https://www.hse.gov.uk/construction/safetytopics/temporary-works.htm

Delivery driver killed in forklift loading incident

Summary

A delivery driver was killed while loading a forklift truck onto a trailer after it fell from the trailer bed. The employer has been fined following an HSE investigation.

What Happened

The incident occurred at a depot in West Yorkshire during the early hours of the morning. The worker had been tasked with returning a forklift truck to a customer following repair work. While reversing the forklift onto a trailer, the vehicle fell from the side of the trailer bed. The worker was thrown from the seat and became trapped between the forklift chassis and a neighbouring trailer. Despite the efforts of the emergency services, the worker sustained fatal injuries and died at the scene.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the forklift truck had not been subject to a full inspection to confirm it was safe to operate. Post-incident examination identified several defects that should have been detected and rectified before the forklift was used.

The investigation also found that, while full pre-delivery inspections were carried out for equipment supplied to new customers, the same checks were not completed for machines being returned to existing customers. In addition, the HSE identified poor seatbelt compliance. Employees rarely wore seatbelts when operating forklift trucks, and there was no system in place to monitor or enforce seatbelt use at the depot.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £433,550 and ordered to pay £8,146.80 in costs and a £2,000 victim surcharge.

Key Learning Points

- Forklift condition must be confirmed before use - All forklift trucks must undergo suitable and sufficient inspection and maintenance checks before being operated, including when equipment is being returned to existing customers—not just when supplied to new ones.
- Inconsistent inspection regimes create serious risk - Applying different safety standards to similar tasks (for example, full checks for new deliveries but not returns) can leave dangerous defects undetected and significantly increase the likelihood of fatal incidents.
- Defective work equipment can have catastrophic consequences - Mechanical defects that should have been identified during inspection can directly contribute to loss of control, falls from height, and crushing injuries.
- Seatbelt use is a critical life-saving control - Where seatbelts are fitted to forklift trucks, they must be worn. Failure to enforce seatbelt use greatly increases the risk of death if a forklift overturns or falls from a trailer.
- Rules without enforcement are ineffective - Employers must actively monitor and enforce safe behaviours, such as seatbelt use, rather than relying on informal practices or assumptions about compliance.
- Loading and unloading vehicles is a high-risk activity - Tasks involving forklifts on trailer beds require careful planning, stable equipment, and competent supervision to prevent falls from height and crushing hazards.
- Learning from near-misses and routine work is essential - Routine tasks carried out frequently can become normalised as “safe”, masking serious risks unless inspections, audits, and behavioural controls are consistently applied and reviewed.

More Information

Further guidance on the safe use of rider-operated lift trucks is available on the HSE website at:
https://www.hse.gov.uk/pubns/books/l117.htm

Member of the public injured in staircase fall at converted property

Summary

A landlord has been fined after a member of the public sustained significant injuries when a defective external staircase failed at a converted residential property in Bristol.

What Happened

In the early hours of 2 October 2023, a group of people were attending a social gathering at a converted property in Bishopston. During the event, a 28-year-old man stepped onto a first-floor external wooden staircase.

As he leant against the handrail on the landing, a section of the handrail gave way. The man fell approximately 11 feet to the concrete-paved ground below, sustaining serious injuries, including head injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) identified fundamental flaws in the design and condition of the staircase. Inspectors found that the structure was rotten, significantly deteriorated, and structurally weakened.
The investigation also highlighted a lack of inspection and maintenance. The staircase had not been subject to an effective regime to identify defects, and was deemed not fit for purpose at the time of the incident.

The Outcome

The landlord pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974. They were fined £20,000 and ordered to pay £4,522 in costs.

Additional Context

HSE inspectors emphasised that staircases, while often perceived as low risk, can present serious hazards if poorly designed or inadequately maintained. In this case, defects would have been readily apparent through routine inspection and timely maintenance.

Key Learning Points

- Landlords have a duty to protect members of the public from risks arising from property conditions.
- External staircases and handrails must be designed to appropriate standards and remain structurally sound.
- Routine inspection and maintenance are essential to identify deterioration such as rot or weakening before failure occurs.
- Seemingly low-risk features, such as staircases, can lead to serious injuries if neglected.

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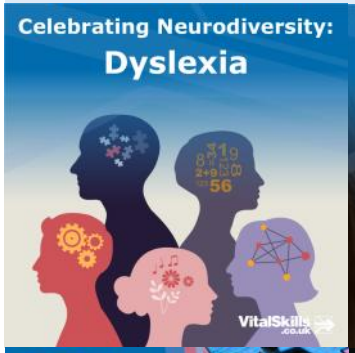

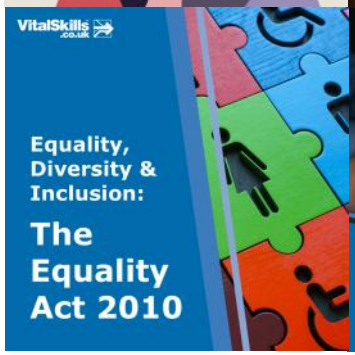

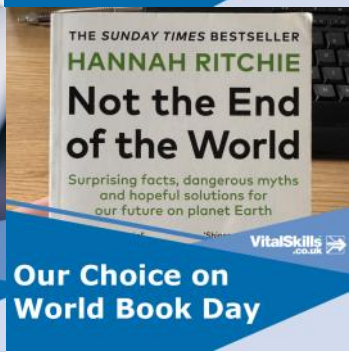

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8hr approx. | All fees included in price

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6-8hr approx. | All fees included in price

IOSH Safety Health and Environment for Construction Site Managers

IOSH | £195 + VAT
16-24hr approx. | All fees included in price

IOSH Managing Safely ®

IOSH | £125.00 + VAT
16-24hr approx. | Includes 5 free courses

IOSH Working Safely ®

IOSH | £60.00 + VAT
6-8hr approx. | All fees included in price

IOSH Environment for Business

IOSH | £95.00 + VAT
5hr approx. | All fees included in price

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ISEP Foundation Certificate in Sustainability & Environmental Mgt.

ISEP | £460.00 + VAT
30-40hr approx. | All fees included in price

ISEP Pathways to Net Zero

ISEP | £175.00 + VAT
10-14hr approx. | All fees included in price

ISEP Environmental Sustainability Skills for Managers

ISEP | £125.00 + VAT
10-14hr approx. | All fees included in price

ISEP Environmental Sustainability Skills for the Workforce

ISEP | ~~£90.00~~ £70.00 + VAT
6-7hr approx. | All fees included in price

Sustainability Short Courses

Environmental Awareness at Home

CPD | FREE
60mins approx. | Includes 5 free courses

Environmental Awareness at Work

CPD | £6.50 - £15.00 + VAT
60mins approx. | Includes 5 free courses

Environmental Awareness for Construction Workers

CPD | £6.50 - £15.00 + VAT
60mins approx. | Includes 5 free courses

Environmental Awareness at Home and Work

CPD | £6.50 - £15.00 + VAT
90mins approx. | Includes 5 free courses

Environmental Awareness - Giving up Plastic

CPD | £6.50 - £15.00 + VAT
60mins approx. | Includes 5 free courses

Health, Safety & Wellbeing Short Courses

Abrasive Wheels Awareness

CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Asbestos Awareness (Category A)

RoSPA & CPD | 180mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Asbestos Awareness (IATP)


IATP | 180mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Asbestos Awareness for Architects and Designers

RoSPA & CPD | 180mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Asbestos Awareness for Architects and Designers (IATP)

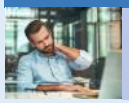
IATP | 180mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Confined Space Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

COSHH Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Display Screen Equipment (DSE) Awareness

CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Display Screen Equipment (DSE) Assessor Awareness

CPD | 120mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Electrical Safety Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Fire Extinguisher Awareness

RoSPA & CPD | 60mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Fire Safety Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Fire Warden / Fire Marshall

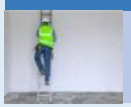
RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Health Safety and Welfare for Workers

RoSPA & CPD | 4.5hr approx. | £12.50 - £25.00 + VAT | Includes 5 free courses

Infection Prevention and Control Awareness

CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Ladder Safety Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Legionella Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Lone Working Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Manual Handling Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Mental Health Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Mental Health Awareness for Managers

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Method Statement Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Moving and Handling People Awareness

CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Noise Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Risk Assessment Awareness

RoSPA & CPD | 90mins approx. | £6.50 - £15.00 + VAT | Includes 5 free courses

Sharps Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Silica Dust Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Slips and Trips Awareness

RoSPA & CPD
60mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Slips, Trips and Falls Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Stress Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Stress Awareness for Managers

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Vibration Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
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Work Equipment Awareness

RoSPA & CPD
90mins approx.
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Working at Height Awareness

RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
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Food Safety & Hygiene Short Courses

Food Allergen Awareness

IoH, RoSPA & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Food Safety and Hygiene - Level 1

IoH, RoSPA & CPD
60mins approx.
£6.00 - £10.00 + VAT
Includes 5 free courses

Food Safety and Hygiene (Retail) Level 2

IoH, RoSPA & CPD
90mins approx.
£6.50 - £12.00 + VAT
Includes 5 free courses

HACCP for Catering Level 2

IoH & CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Food Safety and Hygiene (Catering) Level 2

IoH, RoSPA & CPD
90mins approx.
£6.50 - £12.00 + VAT
Includes 5 free courses

Food Safety and Hygiene (Manufacturing) Level 2

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90mins approx.
£6.50 - £12.00 + VAT
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HACCP for Manufacturing Level 2

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90mins approx.
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HACCP for Retail Level 2

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90mins approx.
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Includes 5 free courses

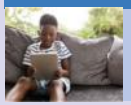
Safeguarding Short Courses

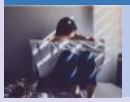
Autism Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Child Mental Health Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Child Online Safety Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Child Sexual Exploitation Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Designated Safeguarding Lead (Children)

CPD
150mins approx.
£12.50 - £25.00 + VAT

Designated Safeguarding Lead (Adults)

CPD
150mins approx.
£12.50 - £25.00 + VAT

Extremism and Radicalisation Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Mental Health Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Mental Health Awareness for Managers

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Modern Slavery Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Safeguarding Children Level 1

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Safeguarding Children (Advanced) Level 2

CPD
120mins approx.
£7.50 - £20.00 + VAT
Includes 5 free courses

Safeguarding Vulnerable Adults Level 1

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Safeguarding Vulnerable Adults (Advanced) Level 2

CPD
120mins approx.
£7.50 - £20.00 + VAT
Includes 5 free courses

Safer Recruitment Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Business Short Courses

Anti-Bribery Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Data Protection and GDPR Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Anti-Money Laundering Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Equality, Diversity and Inclusion Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
Includes 5 free courses

Cyber Security Awareness

CPD
90mins approx.
£6.50 - £15.00 + VAT
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