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Plant hire company fined after bucket crushed mechanic during tipper repair

Summary

A plant hire company has been fined after a mechanic sustained life-changing injuries when a one-tonne JCB bucket fell while being used to support a raised tipper truck body during repairs.

What Happened

On 24 October 2023, an employee was assisting a colleague to repair a broken lifting mechanism on a tipper truck body. A JCB was being used to prop the tipper body in the raised position while work was carried out beneath it. During the repair, the one-tonne bucket became dislodged and fell onto the worker. He sustained multiple fractures to his hand, shoulder blade, ribs, shin and thigh, along with a crushed ankle and foot. As a result of the incident, he also developed a blood clot in his lungs.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that appropriate equipment had not been used to support the raised tipper body. The JCB bucket being used as a prop did not have a quick hitch or retaining pin fitted, which allowed it to become dislodged and fall. HSE guidance on health and safety in motor vehicle repair and associated industries state that elevated vehicle load areas, such as tipper lorry bodies, must be effectively propped if access is required beneath them. Props should be used only on firm, level ground and must be designed to carry the loads imposed.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £10,000 and ordered to pay costs of £3,475.90.

Key Learning Points

- Raised vehicle bodies must be supported using purpose-designed, load-rated equipment.
- Improvised methods of support significantly increase the risk of catastrophic failure.
- Safe systems of work must clearly define how loads will be secured before work begins.
- Equipment used as support must be fitted with appropriate securing mechanisms, such as quick hitches and retaining pins where required.
- Risk assessments should specifically address maintenance tasks involving stored energy and raised loads.



More Information

Further guidance on safe working practices in motor vehicle repair and associated industries is available on the HSE website at: <https://www.hse.gov.uk/pubns/books/hsg261.htm>

Worker crushed by reversing telehandler

Summary

A waste and recycling company has been fined after a worker suffered life-changing injuries when he was crushed against a wall by a reversing telehandler in a Lancashire yard.

What Happened

The incident took place on 12 March 2024 at a waste and recycling site in Lancashire. Four employees were sorting and separating waste by hand in the yard while a colleague operated a telehandler in the same area. One worker was standing against a brick wall at the side of the yard when the telehandler reversed into him, crushing him against the wall.

He suffered multiple fractures, nerve damage to his right arm and internal organ injuries. He also lost partial hearing in his right ear and developed a blood clot that caused damage to his right eye, resulting in permanent sight loss in that eye.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that workers frequently carried out hand-sorting activities in the yard while vehicles were operating alongside them.

HSE found that the company had not carried out a suitable and sufficient assessment of the risks and had failed to put adequate measures in place to safely separate vehicles and pedestrians. There was no physical protection from vehicle movement, despite workers being regularly exposed to significant danger.

The investigation also found that the telehandler operator did not have clear visibility while reversing because the machine was missing mirrors that would have helped with reversing. This defect had not been addressed by the company.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £24,000 and ordered to pay £4,777 in costs.

Key Learning Points

- Pedestrians and vehicles should be effectively segregated wherever workplace transport activities take place.
- Risk assessments must be suitable and sufficient, particularly where vehicles and manual sorting activities take place in the same area.
- Physical controls, not just procedural controls, may be needed to prevent workers being struck or crushed by moving vehicles.
- Vehicles must be properly maintained and fitted with suitable safety features, including equipment that supports safe reversing and operator visibility.

- Employers should review waste handling and recycling operations to ensure workers are not exposed to avoidable workplace transport risks.

More Information

For further guidance, on workplace transport safety see: <https://www.hse.gov.uk/workplacetransport/>

For more information about sorting of recyclables with vehicle assistance see:

<https://www.wishforum.org.uk/wp-content/uploads/2019/06/WASTE-18-.pdf>)



Vibration risks led to prosecution

Summary

A metal fabrication company has been fined after multiple employees developed vibration-related illness linked to their work.

What Happened

The Health and Safety Executive (HSE) became aware in June 2024 of three reports of vibration-related illness among employees working at a site in Immingham Docks, North East Lincolnshire.

This prompted an HSE investigation and the service of an Improvement Notice requiring action to control the ongoing risk.

During the investigation, inspectors identified a further three employees whose illness met the threshold for reporting to HSE. A seventh report was later made by the company.

Employees described the impact the illness was having on their everyday lives. Some experienced finger blanching during routine tasks such as mowing the lawn. Others reported numbness in their hands that kept them awake at night, while some said they were unable to grip properly and had suffered nerve damage.

The Investigation

The HSE investigation found that the company had failed to reduce employees' exposure to vibration to as low a level as was reasonably practicable through organisational and technical measures.

HSE also found that the company had failed to:

- Suitably and sufficiently assess the risks from vibration exposure
- Implement organisational and technical measures to reduce exposure
- Place employees exposed to significant vibration levels under a suitable health surveillance system
- Provide suitable and sufficient information, instruction and training

A new health and safety manager was appointed in June 2022 and had begun work to address issues with the company's vibration management system, but that by then employees had already been significantly exposed to vibration risks.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £44,000 and ordered to pay costs of £8,061.70.

Key Learning Points

- Assess vibration risks thoroughly and review those assessments regularly.
- Reduce exposure using suitable organisational and technical control measures.
- Put appropriate health surveillance arrangements in place for employees exposed to significant vibration levels.
- Provide clear information, instruction and training so workers understand the risks and controls.
- Act promptly when concerns are identified, rather than waiting until ill health has already developed.

More Information

HSE guidance on vibration can be accessed at:
<https://www.hse.gov.uk/vibration/index.htm>

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Chemical manufacturer was fined after two workers were injured in separate incidents

Summary

A chemical manufacturing company was fined after two employees sustained serious injuries in separate incidents at two sites within a three-month period.

What Happened

On 3 September 2021, an employee at one site suffered traumatic injuries when four fingers on his left hand were severed during machinery start-up. Part of the production line was being prepared between cleaning operations. The blades of a rotary valve had not been effectively isolated from the power supply. As the employee checked for air flow, his fingers became trapped between the rotating blades and the valve's internal casing, resulting in amputation.

Less than three months later, on 24 November 2021, a second incident occurred at another site operated by the same company. An employee was struck by a forklift truck after the driver's view was obscured by the load being carried. The driver was unaware that a pedestrian was walking in front of the vehicle at the time of the collision.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that, at the first site, suitable procedures had not been implemented to effectively isolate dangerous machinery between cleaning operations.

A separate investigation into the second incident found that the company had failed to adequately manage forklift truck operations and designated pedestrian routes, resulting in insufficient segregation between vehicles and pedestrians.

The Outcome

The company pleaded guilty to two breaches of Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £50,000 and ordered to pay £10,492.19 in costs, along with a £190 victim surcharge.

In sentencing, the judge acknowledged that the company had made genuine improvements to its health and safety arrangements following the incidents.

Additional Context

HSE guidance emphasises the importance of safe isolation of plant and equipment during cleaning and maintenance activities to prevent contact with dangerous moving parts. Guidance on workplace transport safety also sets clear expectations for site design, traffic management, vehicle visibility and the effective separation of pedestrians and vehicles to prevent collisions.

Key Learning Points

- Ensure effective isolation procedures are in place before cleaning, maintenance or inspection of machinery.
- Verify isolation through testing before any work begins.
- Implement robust workplace transport risk assessments.
- Segregate pedestrians and vehicles wherever reasonably practicable.
- Review arrangements promptly where incidents highlight systemic weaknesses.

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Roofer received suspended sentence after worker fell through rooflight

Summary

A self-employed roofing contractor has received an eight-month suspended prison sentence after a worker fell four metres through a fragile rooflight while carrying out maintenance work at height.

What Happened

On 12 August 2023, a worker was cleaning and repairing gutters and drains on an industrial unit in High Wycombe. He was working alone on the roof of the building.

While walking near the unguarded edges of the roof, he approached a fragile roof covering located above a service road. He stepped onto a rooflight, which gave way beneath him. He fell approximately four metres to the concrete floor below.

The worker sustained serious and life-changing injuries, including a fractured skull and cheekbone, a fractured leg and a broken wrist.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the contractor had failed to implement appropriate work-at-height control measures.

There were no measures in place to prevent workers from:

- Falling from the unguarded edges of the roof
- Falling through fragile roof coverings

Additionally, there were no controls to mitigate either the distance of a fall or the severity of the impact. The investigation also identified a failure to properly plan, manage and control the risks associated with working at height.

The Outcome

The contractor pleaded guilty to breaching Regulation 6(3) of the Work at Height Regulations 2005. He received:

- An eight-month suspended prison sentence
- An order to complete 280 hours of unpaid work
- £500 in costs



Additional Context

Fragile surfaces, including rooflights, are a well-recognised hazard within construction and maintenance activities. Suitable precautions may include edge protection, covers, safety nets, fall arrest systems, and appropriate supervision and planning.



Key Learning Points

- Work at height must be properly planned and risk assessed before work begins.
- Fragile rooflights present a significant and well-known fall risk.
- Workers should not work at height alone where risks are significant and controls are absent.
- Edge protection and fall prevention measures are essential on industrial roofing projects.
- Failure to manage work at height risks can result in life-changing injuries and criminal sanctions, including custodial sentences.

More Information

HSE guidance on working safely at height can be found at:

<https://www.hse.gov.uk/work-at-height/>

Housing maintenance firm fined after worker died from adhesive vapours

Summary

A housing maintenance company has been fined £400,000 after an employee died following exposure to toxic vapours from a flooring adhesive containing Dichloromethane (DCM).

What Happened

On 9 December 2020, a 38-year-old employee was laying a vinyl bathroom floor at a domestic property in Hertfordshire. The adhesive being used contained Dichloromethane (DCM), a highly volatile solvent. Even small quantities can produce large amounts of colourless, low-odour vapour at room temperature.

During the work, the hose connected to a pressurised glue canister became damaged. This resulted in a significant release of adhesive into the poorly ventilated bathroom. The worker lost consciousness and collapsed. Emergency services had to force entry to the bathroom to reach him.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to take appropriate precautions to ensure that substances hazardous to health were not used when safer alternatives were reasonably practicable.

HSE guidance states that DCM-based products should be avoided wherever possible and replaced with safer alternatives. Where their use cannot be avoided, they must only be used in well-ventilated areas to prevent the build-up of

vapour. Poorly ventilated areas include bathrooms, cellars, stairwells and enclosed spaces.

The investigation concluded that the company had not adequately controlled the risks associated with the use of a DCM-based adhesive in a confined domestic bathroom environment.



The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £400,000 and ordered to pay costs of £9,676.81 along with a surcharge of £190.

Additional Context

Dichloromethane (DCM) is a volatile solvent that can rapidly accumulate in confined or poorly ventilated spaces. Because the vapour is colourless and has only a mild odour, dangerous concentrations can build up without obvious warning.

This case highlights the importance of applying the hierarchy of control under the Control of Substances Hazardous to Health (COSHH) Regulations, particularly the need to eliminate or substitute hazardous substances wherever reasonably practicable.

Key Learning Points

- Substitution should be prioritised – Hazardous substances must not be used where safer alternatives are reasonably practicable.
- Ventilation is critical – Confined or poorly ventilated spaces significantly increase the risk of vapour build-up.
- Risk assessments must reflect real working environments – Domestic bathrooms and similar enclosed spaces present foreseeable exposure risks.
- Equipment integrity must be maintained – Damaged hoses or pressurised systems can rapidly escalate exposure risks.
- COSHH principles must be actively applied – Employers must assess, prevent and adequately control exposure to hazardous substances.

More Information

More information about DCM can be accessed at:
<https://www.hse.gov.uk/coshh/essentials/direct-advice/dichloromethane.htm>

More general information about COSHH can be accessed at:
<https://www.hse.gov.uk/coshh/basics/index.htm>



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Man jailed after posing as gas safe registered engineer

Summary

A man has been jailed after falsely claiming to be Gas Safe Registered and carrying out dangerous boiler installation work at the home of a 90-year-old householder.

What Happened

In May 2022, the individual was sent by a contracted company to install a new boiler at a domestic property in Croydon. He had falsely claimed to be qualified and Gas Safe Registered. Although he had never been registered, he installed the boiler and issued a fraudulent gas safety certificate using a Gas Safe Register (GSR) licence number. Concerns were raised by relatives of the householder after the hot water failed and a smell of gas was detected. Despite a separate engineer issuing an ‘immediately dangerous’ notice, the individual returned on more than one occasion, including the day after the notice was issued, and put the boiler back into use. He also demanded payment of his taxi fare to attend. In June the following year, another engineer issued a further immediately dangerous notice and the boiler was fully replaced.

The Investigation

Inspectors from the Health and Safety Executive (HSE) investigated the matter after Gas Safe Register inspectors attended the property. The investigation found that the individual was not registered at the time he installed the boiler and had provided a fraudulent gas safety certificate. It also established that he had continued to carry out gas fitting work following a previous conviction in 2015 and had never been Gas Safe Registered.

The company that sent him to carry out the work had failed to verify that he was registered before engaging him. That company was served with an immediate prohibition notice.

The Outcome

The individual pleaded guilty to breaching Regulations 3(3) and 3(7) of the Gas Safety (Installation and Use) Regulations 1998. He was sentenced to 12 months’ imprisonment.

Additional Context

The Gas Safety (Installation and Use) Regulations 1998 require that anyone carrying out gas work must be Gas Safe Registered and hold appropriate qualifications to demonstrate competence.

Key Learning Points

- Gas work must only be carried out by Gas Safe Registered engineers.
- Clients and contractors must verify registration before engaging individuals for gas work.
- ‘Immediately dangerous’ notices must never be ignored or overridden.
- Fraudulent certification undermines safety controls and places vulnerable people at significant risk.
- Previous enforcement action does not remove ongoing legal duties — repeat offences can result in custodial sentences.

More Information

Further guidance on gas safety and legal requirements is available from the HSE website (see: <https://www.hse.gov.uk/gas/domestic/newschemecontract.htm>) and the Gas Safe Register (see:<http://www.gassaferegister.co.uk/>)

Worker electrocuted after cherrypicker struck overhead powerline

Summary

Two companies have been fined after a worker was killed and a colleague suffered life-changing injuries when a cherry picker came into contact with an overhead powerline at a biogas site.

What Happened

On 1 June 2020, contractors were carrying out work at a biogas facility to lift the lid of a biodigester and stir a crust blockage that had built up inside the tank. During the task, a cherry picker struck an overhead powerline. The electrical current travelled through the metal basket, fatally electrocuting one worker and causing a serious electric shock to another, leaving him with life-altering injuries.

The Investigation

An investigation by the Health and safety Executive (HSE) found that the site operator had previously been advised by both its principal contractor and the electricity network provider to relocate the overhead powerline. This would have removed the risk of contact during construction work and future maintenance activities.

The HSE found that this advice was not acted upon. Adequate control measures were also not put in place, such as height restrictors on cherry pickers or restricted work areas. In addition, supervision, monitoring and site induction arrangements were found to be poor. The investigation also found failings by the contractor carrying out the work. Its risk assessment was not considered suitable or sufficient, and the company lacked formal training provision and adequate supervision for the task being undertaken.

The Outcome

The site operator pleaded guilty to an offence under the Electricity at Work Regulations 1989 and was fined £51,000 and ordered to pay prosecution costs of £28,467.

The contractor pleaded guilty to offences under the Management of Health and Safety at Work Regulations 1999 and the Work at Height Regulations 2005. It was fined £30,000 and ordered to pay prosecution costs of £8,000.

Key Learning Points

- Work near overhead powerlines should be avoided wherever possible by eliminating the risk at source.
- Known hazards should be addressed when identified, particularly where specialist advice has already been provided.
- Risk assessments must be suitable and sufficient for the actual task being carried out.
- Safe systems of work should include practical controls such as exclusion zones, height restriction measures and clear supervision arrangements.
- Workers involved in higher-risk activities must receive adequate training, information and supervision.

More Information

HSE has guidance on working safely near overhead electricity power lines (see: <https://www.hse.gov.uk/pubns/ais8.pdf>)

There is also recognised industry guidance is available via Look Out Look Up (see: <https://www.energynetworks.org/assets/images/2025/250626look-out-look-up-general-guidance-e.version.pdf>)



Worker killed while operating ride-on mower near pond

Summary

A grounds maintenance company was fined after a worker died when a ride-on lawnmower entered a village pond while being operated on sloping ground.



The lawnmower involved

What Happened

On 8 October 2021, a 23-year-old employee was cutting grass around a village pond near Ripon. While operating a ride-on mower close to the water's edge, the machine descended a steep incline and entered the pond.

The mower was not fitted with a roll-over protection system (ROPS) at the time of the incident.



The location where the incident occurred

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to carry out a suitable and sufficient site-specific risk assessment for the work being undertaken.

The investigation also established that the mower's roll-over protection system (ROPS) had been removed at some point prior to the work taking place. ROPS are designed to protect operators if machinery overturns and are particularly important when working on uneven or sloping ground.

The Outcome

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

It was fined £27,000 and ordered to pay £11,166 in costs at a Magistrates' Court.

Additional Context

Ride-on mowers are commonly used in grounds maintenance, but they present significant risks when operated on slopes or near water.

Suitable risk assessment is essential when operating ride-on machinery, particularly on uneven terrain. Employers must ensure equipment is appropriate for the conditions and fitted with all necessary safety features.

Removing or failing to maintain safety-critical components such as ROPS can significantly increase the likelihood and severity of overturn incidents.

Key Learning Points

- Always carry out a site-specific risk assessment before operating ride-on machinery.
- Ensure roll-over protection systems (ROPS) are fitted and maintained when working on slopes or uneven ground.
- Consider terrain and proximity to water when planning grounds maintenance activities.
- Do not remove or disable safety-critical features on machinery.
- Provide clear supervision and controls for higher-risk outdoor tasks.

More Information

Risk assessment templates and examples,, from the HSE, can be accessed at:

<https://www.hse.gov.uk/simple-health-safety/risk/risk-assessment-template-and-examples.htm>

Builder prosecuted after obstructing HSE inspectors

Summary

A site manager has been fined after obstructing inspectors from the Health and Safety Executive (HSE), threatening them and refusing to allow access to a refurbishment site in Staffordshire.



What Happened

On 11 February 2025, two HSE inspectors were carrying out routine inspections in the Rugeley area when they observed unsafe work at a cottage refurbishment project.

Two individuals were accessing a roof from the bucket of an excavator — a clearly unsafe practice that required immediate intervention. There were around ten workers on site when the inspectors approached. The site manager refused to identify himself, instead claiming his name was “James Bond”. He stated that he was the property owner, that the individuals on site were unpaid friends and relatives, and that the inspectors had no legal right to inspect the premises.

The inspectors were met with threats of violence and withdrew from the site.

A week later, the inspectors returned accompanied by Staffordshire Police officers. The site manager again refused to co-operate, instructed workers not to speak to the HSE (except to claim they were relatives), and maintained that the inspectors had no right to inspect the site.

Following further enquiries, the individual was formally identified as the site manager and enforcement action was taken.

The Outcome

The individual was charged with two counts of obstruction under Section 33(1)(h) of the Health and Safety at Work etc. Act 1974.

After being notified of the prosecution, he sent three expletive-laden emails to the regulator and stated that he would not comply.

The individual failed to attend the Magistrates’ Court on two occasions and was ultimately tried in his absence.

On 9 January, the court found the site manager guilty in his absence.

He was fined £3,000, ordered to pay £6,450 in costs and a victim surcharge of £1,200.

Additional Context

HSE inspectors conduct more than 13,000 inspections each year across Great Britain. Proactive inspections are a key mechanism for identifying unsafe practices, advising dutyholders, and preventing harm.

The regulator has made clear that while enforcement is used proportionately, obstruction of inspectors will not be tolerated.

Key Learning Points

- Obstructing an HSE inspector is a criminal offence under the Health and Safety at Work etc. Act 1974.
- Inspectors have wide-ranging powers to enter premises, request information and investigate unsafe practices.
- Threatening or abusing regulators constitutes work-related violence and may result in prosecution.
- Unsafe work at height — including improvised access methods — requires immediate corrective action.
- Professional and co-operative engagement with regulators protects both workers and organisations.

More Information

Further guidance on HSE’s powers of inspection and enforcement can be found on the HSE website.

Worker burned by corrosive chemical at manufacturing site

Summary

A manufacturer of household cleaning products has been fined after an agency worker sustained burns to her face and upper body when she was sprayed with a corrosive sink and drain un-blocker.

What Happened

On 2 November 2023, an agency worker was part of a team decanting sink and drain un-blocker liquid from 1,000-litre bulk containers into smaller containers for retail sale. The bulk containers were positioned at shoulder height. During the process, the worker accidentally opened the outlet valve on an adjacent container that was not connected to a decanting hose and did not have an end cap fitted.

The corrosive liquid was released under considerable pressure, spraying her in the face, eye, neck and arm. She suffered painful burns, including injuries to her eyelid and eye, and was unable to work for a significant period. She has since made a reasonable recovery and returned to work.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company's system of work exposed workers to foreseeable risks in the event of leaks or loss of containment.

The investigation identified:

- Unsafe decanting arrangements, including handling large volumes of corrosive liquid stored at or above shoulder height

- Inadequate training arrangements, particularly for workers with limited understanding of English
- Failure to ensure personal protective equipment (PPE) was consistently worn
- Insufficient supervision and monitoring of safe working practices
- Inadequate first aid arrangements, including the absence of emergency drenching facilities such as a safety shower

HSE guidance under the Control of Substances Hazardous to Health Regulations (COSHH) requires employers to assess risks from hazardous substances and implement effective control measures. This includes safe systems of work, appropriate training and supervision, suitable PPE, and adequate emergency arrangements.

The Outcome

The company pleaded guilty to breaches of Section 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £50,000 and ordered to pay £7,247.40 in costs, along with a £2,000 victim surcharge.

Additional Context

Following the incident, the company changed its working methods to eliminate the identified risks, including improving the way corrosive liquids are handled and stored during decanting operations.

Key Learning Points

- Avoid decanting hazardous substances from containers stored at or above shoulder height where practicable.
- Ensure outlet valves and connections are clearly identified, secured and capped when not in use.
- Provide training that is accessible and understood by all workers, including those with limited English proficiency.

- Actively monitor and enforce the use of appropriate PPE.
- Ensure emergency arrangements match the scale of potential exposure, including suitable eye wash and drenching facilities.

More Information

For further guidance, visit the HSE webpages on the Control of Substances Hazardous to Health (COSHH) Regulations and safe handling of hazardous substances at:

<https://www.hse.gov.uk/coshh/basics/overview.htm>

HSE has updated its guidance for the waste industry

Summary

The Health and Safety Executive (HSE) has refreshed its guidance on the waste and recycling industry, with the intent of protecting people and places in the sector more easily.

Through working with the Waste Industry Safety and Health Forum (WISH), the HSE have:

- Removed outdated or duplicated information
- Brought guidance up to date, so it reflects changes in the industry
- Reduced the size of the site substantially, so it will be easier for users to find the advice they need

More information

For more information, see:

<https://www.hse.gov.uk/waste/index.htm>

Worker killed when granite slabs fell from lorry loader

Summary

A stone company has been fined after a worker was fatally injured when granite slabs fell from a lorry loader during offloading operations at its premises in Scotland.

What Happened

On 4 September 2024, a 61-year-old worker was offloading granite slabs from a lorry loader at the company's premises in Larkhall.

The worker was positioned on top of the flatbed section of the vehicle when two granite slabs, with a combined weight of more than 900 kilograms, fell and struck him. He sustained fatal injuries as a result of the incident.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that vertical safety posts — designed to act as a physical barrier to prevent slabs from toppling — had been removed during the offloading operation. Although it was accepted that it was customary practice for these posts to remain in place during offloading, this requirement was not specified within the company's Safe System of Work.

The investigation also identified that lifting two slabs at once was a regular practice. However, the Safe System of Work did not distinguish between single-slab and multiple-slab lifting operations, nor did it provide specific instructions for handling more than one slab at a time.

In addition, the worker was operating alone, despite the Safe

System of Work stating that two people should be involved in offloading activities.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £50,000 and ordered to pay a victim surcharge of £3,750.

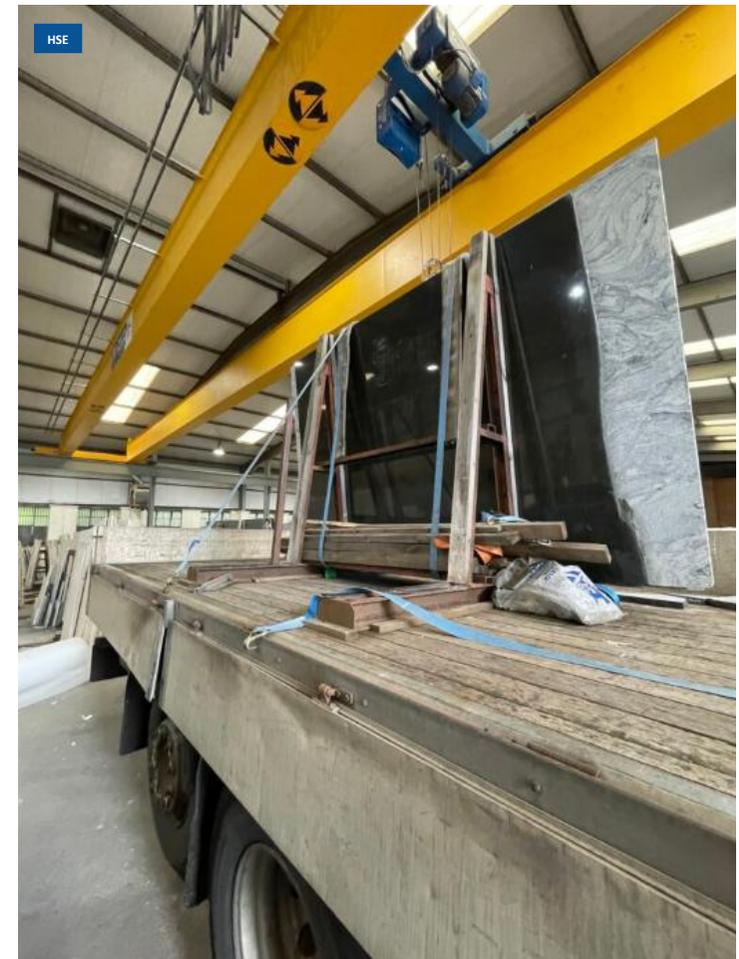
Additional Context

The handling and storage of large sheet stone slabs presents significant risk due to their weight, size and potential instability. The removal of physical restraints and deviations from established systems of work can rapidly increase the likelihood of serious injury or fatality.

The HSE highlighted that safe systems of work must be sufficiently detailed to address foreseeable risks, including ensuring that safety equipment remains in position and that adequate personnel are present during hazardous lifting operations.

Key Learning Points

- Safe systems of work must clearly define controls for all variations of a task, including single and multiple-item lifting.
- Physical safeguards, such as vertical safety posts, should remain in place unless a risk assessment justifies their removal.
- Lone working during high-risk lifting operations should be avoided where procedures specify additional personnel.
- Custom and practice is not a substitute for clearly documented and communicated safety requirements.
- Regular review of lifting operations under LOLER is essential to ensure controls remain effective and appropriate.



More Information

Further guidance is available from the HSE on the handling and storage of large sheet stone slabs: <https://www.hse.gov.uk/stonemasonry/handling-storage-slabs.htm>.

For the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998, see: <https://www.hse.gov.uk/work-equipment-machinery/loler.htm>

Steam release near miss at chemical plant

Summary

A global chemicals company has been fined £400,000 after a contractor narrowly avoided serious injury when high-pressure steam was unexpectedly released during maintenance work at a production site in Huddersfield.

What Happened

On 6 November 2023, a 59-year-old mechanical fitter was carrying out planned maintenance on small-bore pipework within a high-pressure steam distribution system. The work involved replacing a faulty steam trap.

Steam traps are designed to remove condensate and air from high-pressure steam systems. During the task, the contractor began separating a bolted flange by cutting through the bolts with a battery-powered reciprocating saw. At that point, the isolation valve intended to separate the work area from the live steam supply suddenly failed. This resulted in an uncontrolled release of high-pressure steam. The incident was reported to the Health and Safety Executive (HSE) as a dangerous occurrence.

The Investigation

An investigation by the HSE found that the incident occurred during the planned replacement of a faulty steam trap. The investigation identified several significant failings:

- The isolation valve failed while the flange was being separated.
- The isolation valve and flange bolts were heavily corroded and in poor condition.
- Due to widespread corrosion across the steam distribution

system, it had become routine practice to cut flange bolts rather than unscrew them.

- Cutting bolts reduced the ability to control any trapped pressure or material remaining within the pipework.

The HSE concluded that the company had failed to maintain the isolation valve and associated bolts in an efficient state, efficient working order and in good repair, as required under Regulation 5(1) of the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The investigation also identified failings in the documented risk assessment process. Maintenance work on small-bore pipework was routinely carried out using a single method of isolation.

HSE guidance, including HSG253 The Safe Isolation of Plant and Equipment, emphasises that double isolation methods provide a safer approach. The risk assessment in place did not sufficiently recognise the increased risk associated with relying on a single isolation method in the presence of known corrosion.

The company also failed to make a suitable and sufficient assessment of the risks associated with the specific maintenance activity, contrary to Regulation 3(1) of the Management of Health and Safety at Work Regulations 1999.

The Outcome

The company pleaded guilty to both offences. It was fined £400,000 and ordered to pay costs of £8,288.

An HSE inspector stated that the incident could have been prevented had a safe system of work been in place. The inspector highlighted that the company failed both to produce

an appropriate risk assessment and to maintain work equipment in a safe condition, describing the situation as a “dangerous accident waiting to happen”.

Additional Context

High-pressure steam systems present significant hazards, particularly during maintenance activities. Known corrosion within pipework and fittings substantially increases the risk of component failure.

Routine reliance on single isolation methods where degradation is present can expose workers to uncontrolled releases of energy. Established guidance supports the use of double isolation and verification procedures to reduce this risk.

Key Learning Points

- Maintain work equipment properly – Corrosion and degradation must be proactively identified and addressed under PUWER.
- Avoid normalising degraded conditions – Adapting working methods (such as routinely cutting bolts) can mask deeper systemic failures.
- Use double isolation where appropriate – Particularly in high-pressure systems or where equipment condition is uncertain.
- Ensure risk assessments reflect actual conditions – Generic or routine assessments must be reviewed where plant condition changes.
- Plan maintenance with energy release in mind – Always assume residual pressure may be present unless proven otherwise.

More Information

See: <https://www.hse.gov.uk/pubns/books/hsg253.htm>

Worker's fingers severed in printing machine incident

Summary

A wooden cable drum manufacturer was fined after an employee's fingers were partially severed while cleaning a printing machine.

What Happened

On 8 March 2024, a 57-year-old employee was working at a wooden cable drum manufacturing site in South Kirkby. The worker was cleaning the rollers of a machine used to print logos onto products.

She was able to raise the machine guard and override an interlock, allowing the rollers to operate while exposed. While cleaning the rollers with a paper towel, her fingers were drawn into the nip point between the moving rollers. Two of her fingers were left partially severed as a result.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to prevent access to dangerous parts of machinery, specifically the moving rollers of the printing machine. The investigation also identified that the machine had not been adequately maintained and that employees had not received suitable training in relation to the operation and safety devices of the printer.

HSE guidance states that employers must take effective measures to prevent access to dangerous parts of machinery. This includes ensuring that protection devices, such as interlocks, are not easily bypassed or disabled. Further guidance is available under the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £24,395, ordered to pay £5,000 in costs and a victim surcharge of £2,000.

Key Learning Points

- Ensure guards and interlocks cannot be easily bypassed or overridden.
- Regularly inspect and maintain machinery to confirm safety devices function as intended.
- Provide suitable and sufficient information, instruction and training before employees carry out cleaning or maintenance tasks.
- Never allow cleaning of rollers or moving parts while machinery is running unless specifically designed and risk assessed for that purpose.
- Undertake suitable and sufficient risk assessments in line with PUWER requirements.

More Information

For guidance on machinery safety and the Provision and Use of Work Equipment Regulations 1998 (PUWER), visit the HSE website at:

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



Worker lost finger in lathe polishing incident

Summary

A machine manufacturing company has been fined after an employee lost a finger while polishing metal components on a lathe using emery cloth.

What Happened

On 26 April 2024, an employee was polishing metal work pieces on a rotating lathe using emery cloth. While carrying out this task, his glove became caught in the rotating machinery and was drawn into the lathe.

As a result of the incident, the employee suffered severe injuries to his right hand and subsequently required the amputation of one finger. He was unable to return to his profession as a turner and was later made redundant.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to adequately assess the risks associated with polishing work pieces using emery cloth on a lathe.

The investigation also identified that the company had not implemented a safe system of work for this activity.

HSE guidance states that emery cloth should never be applied directly by hand to work rotating in a lathe. Acceptable methods include securing the cloth using the tool post as a clamp or using a dedicated holding device, both of which significantly reduce the risk of entanglement and serious 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 £10,000 and ordered to pay £3,758.55 in costs, together with a £2,000 victim surcharge.

Additional Context

Entanglement in rotating machinery is a recognised hazard in manufacturing environments. The use of gloves, loose clothing, or hand-held materials near rotating parts significantly increases the risk of being drawn into the machine.

Established industry guidance makes clear that direct hand application of emery cloth to rotating work is unsafe and should be replaced with controlled methods that remove hands from the danger zone.

Key Learning Points

- Direct hand use of emery cloth on rotating lathes presents a serious entanglement risk.
- Risk assessments must specifically address non-routine or finishing tasks such as polishing.
- Safe systems of work should eliminate or control the risk of contact with rotating parts.
- Employees must be trained in approved polishing methods and supervised to ensure compliance.
- Wearing gloves near rotating machinery can increase the severity of entanglement injuries.

More Information

HSE guidance on the safe use of emery cloth on metalworking lathes can be accessed at:

<https://www.hse.gov.uk/engineering/lathes.htm>




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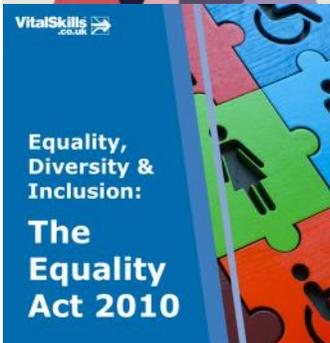


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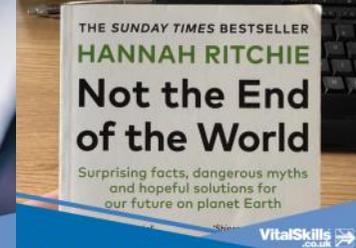


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