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## Worker died after becoming entangled in lathe

### Summary

A forge company has been fined £750,000 after a machinist sustained fatal injuries when he became entangled in a 20-metre long lathe while using handheld emery cloth.

### What Happened

On 8 December 2023, a 54-year-old machinist was working in the machine shop. He was using handheld emery cloth to finish a rotating component on a large lathe.

During the task, he became entangled in the dangerous moving parts of the machine and sustained catastrophic injuries. Despite the efforts of emergency services, he died later that evening.

### The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to:

- Prohibit the use of handheld emery cloth on lathes
- Prevent access to dangerous moving parts of the lathe
- Ensure that personal protective equipment (PPE) worn by workers did not create a risk of being drawn into the machinery
- Undertake a suitable and sufficient risk assessment for the lathe
- Establish a safe operating procedure

HSE guidance on using emery cloth on metalworking lathes makes clear that it is never acceptable to apply emery cloth by hand to a rotating component, due to the risk of entanglement and being dragged into the danger zone.

### The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £750,000 and ordered to pay £38,314 in costs.



### Key Learning Points

- Never use handheld emery cloth on rotating components. Alternative safe methods must be adopted.
- Eliminate access to dangerous moving parts. Guards, interlocks and engineered controls must not be bypassed or absent.
- Assess PPE risks as well as benefits. Clothing or equipment that can increase entanglement risk must be carefully considered.
- Risk assessment must be task-specific. High-risk machinery requires detailed, suitable and sufficient assessment.
- Safe systems of work must be formalised and enforced. Informal practice is not an adequate control.

### More Information

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

# Deadly asbestos risks ignored during demolition work

## Summary

Two Midlands companies and a site manager have been sentenced after unsafe demolition work led to a large-scale asbestos disturbance and an unlawful asbestos clear-up operation, creating a risk of exposure for workers and members of the public.

## What Happened

Concerns were raised about unsafe demolition work at a site in Cannock. When a Health and Safety Executive (HSE) inspector visited, demolition had already been stopped after asbestos had been discovered.

A later refurbishment and demolition asbestos survey identified 218 square metres of asbestos-containing materials and debris.

Before work began, the client had commissioned an asbestos management survey, which identified some asbestos-containing materials within the building. That survey was shared with the demolition contractor. Despite this, demolition work still went ahead while asbestos was known to be present.

After the more detailed refurbishment and demolition survey was completed, the client obtained a quotation from a licensed asbestos removal contractor. However, instead of appointing that contractor, another company and its site manager were engaged to carry out the asbestos clear-up, even though they did not hold the necessary licence or competence to undertake that work.

## The Investigation

The Health and Safety Executive (HSE) investigation found a number of serious failings.

The client had failed to appoint a principal contractor to manage the construction project, as required by the Construction (Design and Management) Regulations 2015. The demolition contractor proceeded with demolition work despite being aware that asbestos was present.

The company and site manager later appointed to deal with the asbestos clear-up were not licensed or competent to undertake the work. The site manager also failed to engage a licensed contractor and failed to ensure suitable controls were in place to prevent exposure to, and the spread of, asbestos fibres.



HSE reminded dutyholders that, under the Control of Asbestos Regulations 2012, a refurbishment and demolition asbestos survey must be carried out before starting work likely to disturb the fabric of a building built before 2000. Where asbestos-containing materials are identified, they must either remain undisturbed or be removed under properly controlled

conditions by a competent contractor and, where required, an HSE-licensed contractor.

## The Outcome

The client company was fined £74,900 and ordered to pay costs of £3,658.14 and a statutory surcharge of £2,000.

The demolition contractor was fined £13,400 and ordered to pay costs of £1,359.51 and a statutory surcharge of £2,000.

The site manager received a 26-week prison sentence, suspended for two years, and was made subject to an electronically monitored curfew between 19:00 and 07:00 for three months. He was also disqualified from acting as a director for five years. In addition, he was ordered to pay costs of £5,899 and a statutory surcharge of £154.

## Key Learning Points

- Do not begin demolition or refurbishment work until asbestos risks have been properly identified and assessed.
- An asbestos management survey is not a substitute for a refurbishment and demolition asbestos survey where the work will disturb the fabric of a building.
- If asbestos is identified, work must be planned and managed so that exposure is prevented or strictly controlled.
- Dutyholders must appoint competent people and, where required, licensed asbestos contractors.
- Construction projects must have the required management arrangements in place, including appointment of a principal contractor where the regulations require one.
- Failing to manage asbestos properly can place not only workers, but also members of the public, at risk.

## Two workers killed in racking collapse during load testing

### Summary

Two workers died after an industrial racking system collapsed during load testing at an industrial estate in West Yorkshire.

### What Happened

On 29 October 2020, an industrial racking system was being tested using weighted loads at a site on an industrial estate.

The structure was being loaded with test weights, some weighing up to two tonnes, when it began to collapse. The two workers were operating from a mobile elevating work platform (MEWP) positioned next to the racking as the loading took place.

As the racking failed, it struck the MEWP, causing it to overturn with both workers inside. Both men sustained fatal injuries and died shortly afterwards.

### The Investigation

An investigation by the Health and Safety Executive (HSE) found that the companies involved had failed to adequately assess the risks associated with the load testing activity.

HSE determined that there was no safe system of work in place to protect those involved. Workers were positioned within the potential collapse zone of the racking structure during testing, exposing them to serious risk in the event of structural failure.

The planned and implemented systems of work were found to be unsafe.

### The Outcome

One company pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £97,500 and ordered to pay £17,377 in costs.

A second company pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £60,000 and ordered to pay £10,292 in costs.

### Additional Context

Load testing of racking systems involves introducing significant forces into a structure. Without appropriate engineering controls, exclusion zones, and clear safe systems of work, structural instability can develop rapidly.

Positioning workers within a potential collapse zone during structural testing significantly increases the risk of serious or fatal injury if failure occurs.

### Key Learning Points

- Structural testing activities must be supported by a suitable and sufficient risk assessment.
- Exclusion zones should be established and enforced during load testing.
- Workers should never be positioned within a foreseeable collapse zone.
- Safe systems of work must be clearly planned, documented and implemented.
- Senior management oversight is essential when undertaking high-risk engineering activities.

### More Information

For guidance on risk assessment and safe systems of work, visit the HSE website at:

<https://www.hse.gov.uk/risk/>

## New Online Course Releases

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### CV Writing for Education Leavers

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### Health Safety and Welfare for the Workforce

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## Worker fractured hip after fall from pallet box

### Summary

A bakery company has been fined after an employee fractured their hip when they fell from a large plastic pallet box while disposing of food waste into a skip.

### What Happened

The incident happened on 15 April 2024. The employee had been standing on a large plastic pallet box in order to reach the top of a skip and dispose of food waste. During this activity, they fell and suffered a fractured hip.

### The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to carry out a suitable and sufficient risk assessment for loading skips. It also found that appropriate equipment had not been provided to allow safe access for the task. In addition, inadequate supervision and monitoring meant that unsafe working at height practices had become commonplace.

### The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £16,667 and ordered to pay costs of £4,333.66, together with a victim surcharge of £2,000.

### Additional Context

The incident highlights the risks created when unsuitable items are used as a means of access for work at height. Standing on a pallet box to gain height exposed the employee to a foreseeable risk of falling. The case also underlines the importance of risk assessment, suitable equipment, and effective supervision to prevent unsafe practices from becoming normalised in the workplace.

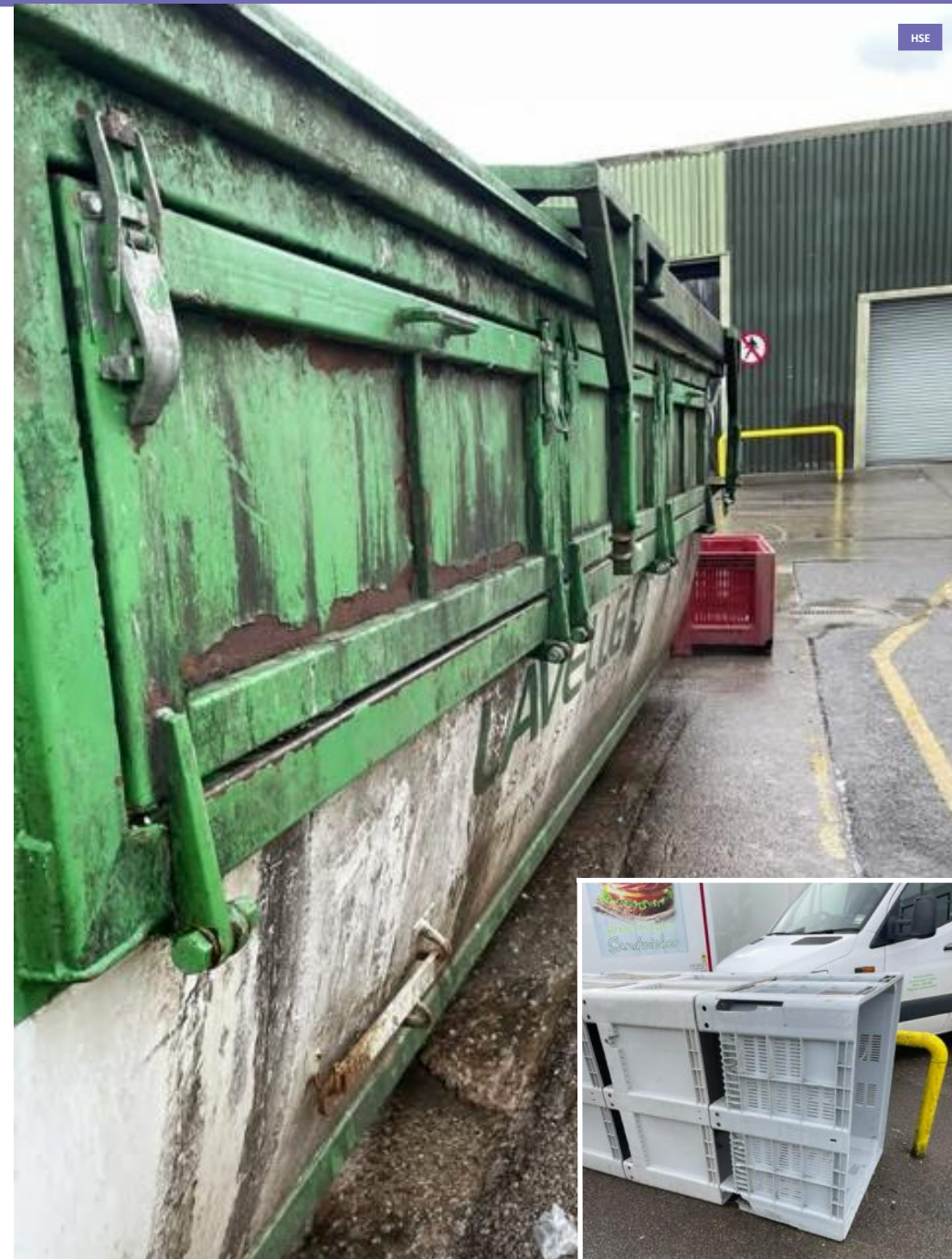
### Key Learning Points

- Work at height must be properly planned and supported by a suitable and sufficient risk assessment.
- Workers should be provided with appropriate access equipment for the task, rather than relying on unsafe improvised methods.
- Unsafe practices can become routine if supervision and monitoring are not effective.
- Employers should review waste disposal arrangements where employees need to access skips or other elevated areas.
- Working at height remains a significant cause of workplace injury and requires consistent control measures.

### More Information

Information about risk assessment can be accessed at:

<https://www.hse.gov.uk/simple-health-safety/risk/index.htm>



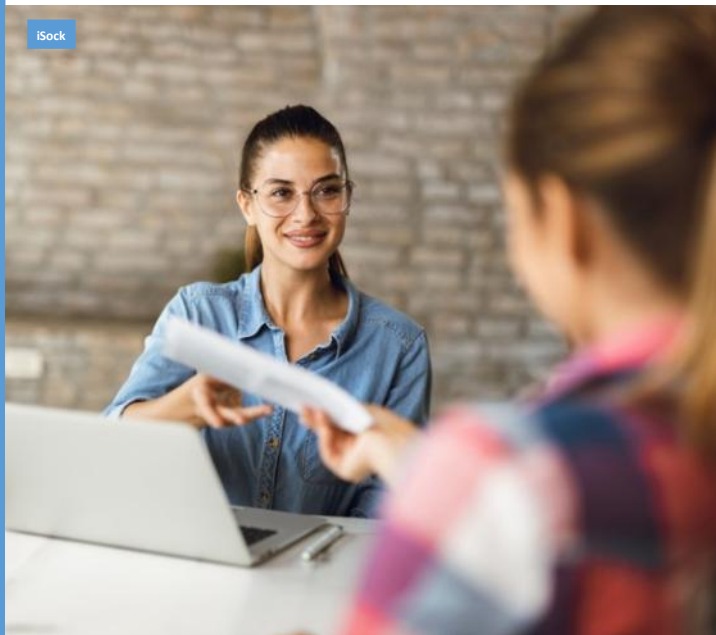
## Two new FREE courses: CV writing and CV writing for education leavers

Helping People Take the Next Step: Two New Free CV Courses  
For many people, writing a CV feels like a task they should know how to do — but rarely feel confident about.

### What do employers actually look for?

- How do you stand out when everyone seems to have similar experience?
- How do you get past the systems that filter applications before a human even sees them?

These are common questions, whether someone is starting out or looking to move forward.



With that in mind, we've introduced two new free courses designed to make the process clearer, more practical, and ultimately more effective:

- CV Writing
- CV Writing for Education Leavers

### Two courses, one clear purpose

Both courses are built around a simple idea: A CV is not just a document — it is a tool to communicate value.

They take learners step-by-step through the process of creating a CV that is not only well presented, but purposeful — one that reflects strengths, demonstrates impact, and aligns with what employers are actually looking for.

Across both courses, learners explore:

- How CVs are really used in recruitment decisions
- What makes a strong first impression (and what undermines it)
- How to turn responsibilities into clear, evidence-based achievements
- How to tailor applications to specific roles
- How modern recruitment systems (including ATS) influence outcomes
- How to structure, format, and refine a CV so it works in practice

### Designed for different starting points

While the core principles are consistent, the two courses recognise that not everyone starts from the same place.

CV Writing is aimed at those with some level of work experience — helping them better articulate what they've done and the value they bring.

CV Writing for Education Leavers takes a slightly different angle. It supports those earlier in their journey, where experience may be limited, by focusing on:

- Translating education, activities, and early experiences into meaningful content
- Understanding early-career recruitment expectations
- Avoiding common pitfalls such as overuse of jargon, abbreviations, or informal language

### Practical, structured, and focused on real outcomes

Each course follows a clear structure, guiding learners from understanding the purpose of a CV through to producing a polished, tailored version ready for use.

Importantly, the focus is not just on writing a CV — it is on:

- Thinking differently about personal experience
- Recognising and articulating achievements
- Adapting content for different opportunities
- Continuously improving through feedback

### Why this matters

A well-written CV can open doors. A poor one can close them.

Whether someone is entering the job market for the first time or looking to take the next step, the fundamentals remain the same — clarity, relevance, and impact.

### More information

We are offering both courses, **completely free of charge**, with no strings attached.

CV Writing: <https://hsqe.co.uk/courses/cv-writing/>

CV Writing for Education Leavers:

<https://hsqe.co.uk/courses/cv-writing-for-education-leavers/>

# Illegal gas work led to suspended prison sentence

## Summary

A tradesperson received a suspended prison sentence after carrying out illegal gas work on a domestic property, creating an immediate risk of carbon monoxide poisoning.



## What Happened

In February 2023, gas work was undertaken at a property in Bournemouth, Dorset. The work included relocating a gas boiler and its flue.

Following installation, the homeowners identified concerns about the standard of the work and arranged for another engineer to inspect the system. The boiler was subsequently classified as “immediately dangerous”. The flue had not been sealed or positioned correctly, creating a risk that carbon monoxide could leak into the property.

## The Investigation

An investigation by the Health and Safety Executive (HSE) found that the individual who carried out the work had no training in gas work and was not registered with the Gas Safe Register.

The investigation also established that he knew registration was required, as he had previously been a director of a company that had been registered.

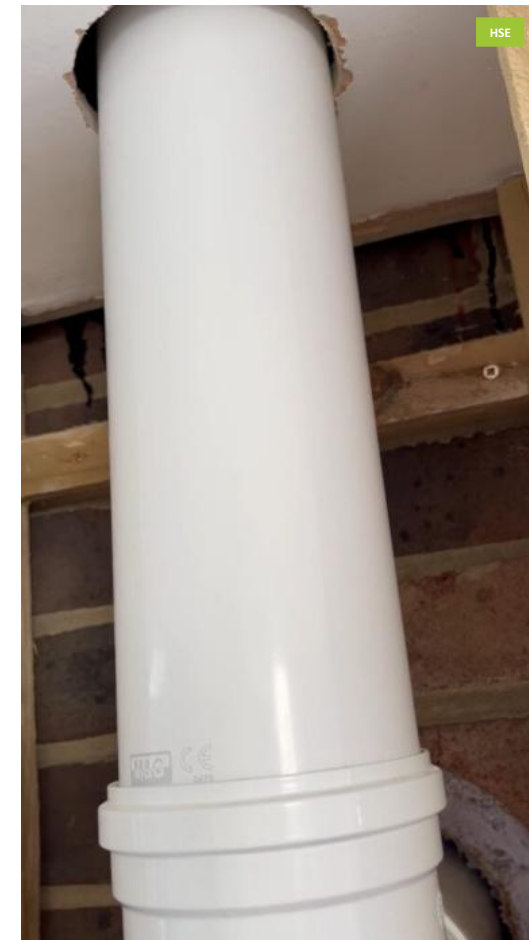
Under the Gas Safety (Installation and Use) Regulations 1998, anyone undertaking gas work must be Gas Safe registered and hold relevant qualifications to demonstrate competence.

## The Outcome

The individual pleaded guilty to breaching Regulations 3(3), 27(1) and 27(5) of the Gas Safety (Installation and Use) Regulations 1998. He was sentenced to 10 months’ imprisonment, suspended for 12 months. He was also ordered to pay £3,907 in compensation to the homeowner and £7,064 in costs. In addition, a six-month electronic monitoring order was imposed, restricting his movements at weekends.

## Key Learning Points

- Gas work must only be undertaken by appropriately trained and Gas Safe registered engineers.
- Improper installation of boilers and flues can create an immediate risk of carbon monoxide exposure.
- Homeowners should always verify an engineer’s registration before permitting gas work.
- Organisations and sole traders undertaking regulated work without competence or registration are likely to face prosecution.



The gas boiler flue was not sealed or correctly positioned

# Illegal gas work put family at risk

## Summary

A man has been sentenced after carrying out illegal gas work that resulted in multiple gas leaks at a domestic property, leaving a family without heating or hot water for six weeks.



## What Happened

In February 2024, gas work was carried out at a family home in Ulverston, including the installation of a gas combi boiler and associated pipework. Shortly after the work was completed, one of the occupiers detected the smell of gas near the meter box and contacted Cadent. Engineers identified three separate gas leaks. As a result, the gas supply to the property was shut off for six weeks, leaving the family of four without heating or hot water during that period.

## The Investigation

The Health and Safety Executive (HSE) was notified of the incident by the Gas Safe Register following their inspection, which classified the installation as Immediately Dangerous.

The HSE investigation found that the individual who carried out the work:

- Held no recognised qualifications in relation to gas work
- Was not competent to undertake gas work safely
- Was not registered with the Gas Safe Register

The Gas Safety (Installation and Use) Regulations 1998 require anyone carrying out gas work to be Gas Safe registered and appropriately qualified. Failure to meet these requirements presents serious risks, including gas leaks, fires, explosions, and carbon monoxide poisoning.

## The Outcome

The individual pleaded guilty to breaching Regulations 3(1) and 3(3) of the Gas Safety (Installation and Use) Regulations 1998.

He was sentenced to:

- A 12-month community order
- 200 hours of unpaid work
- £2,000 in costs

Following the hearing, an HSE Inspector stated that the risks from uncontrolled gas leaks are well known and can be fatal, and that enforcement action will be taken against those undertaking gas work without the required competence or registration.

## Additional Context

Gas work must only be carried out by engineers who are registered with the Gas Safe Register.

Members of the public can verify an engineer's registration status online or by telephone before permitting any work to proceed.

Unregistered gas work is illegal and can place occupants at significant risk.

## Key Learning Points

- Verify competence – Always confirm that gas engineers are Gas Safe registered and appropriately qualified before work begins.
- Recognise the warning signs – The smell of gas must be treated as an immediate safety issue.
- Understand legal duties – The Gas Safety (Installation and Use) Regulations 1998 place clear legal obligations on those undertaking gas work.
- Appreciate the consequences – Unsafe gas work can lead to life-threatening incidents and criminal prosecution.

## 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/>)

# Police force fined after officer was struck by car on unlit road

## Summary

A police force has been fined after a student officer sustained life-threatening and life-changing injuries when he was struck by a vehicle while managing traffic at the scene of a collision.

## What Happened

On 24 December 2023, a 22-year-old student officer was responding to a traffic collision in Shropshire.

The original collision occurred on a single carriageway subject to the national speed limit of 60 mph. The road had no street lighting and included a bend. The officer was positioned on the bend managing traffic when he was hit by a passing car. He suffered life-threatening and life-changing injuries as a result of the incident.

## The Investigation

An investigation by the Health and Safety Executive (HSE) found that the police force failed to do all that was reasonably practicable to manage risks associated with responding to traffic collisions.

The investigation identified that:

- Risk assessments were not suitable and sufficient.
- Adequate equipment for safely responding to traffic collisions had not been provided.
- There was a lack of suitable information, instruction and training for officers.

As a result, both employees and members of the public were exposed to unnecessary risks.

The investigation also noted that in June 2021 the National Police Chiefs' Council had issued recommendation reports to all UK police forces, providing advice on implementing road safety improvements following an officer and staff safety review.

## The Outcome

The Office of Chief Constable West Mercia Police pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. The force was fined £85,800 and ordered to pay £9,402 in costs.

## Additional Context

Incidents involving live traffic present significant risks, particularly on high-speed roads with poor visibility or limited lighting. Effective planning, dynamic risk assessment, appropriate equipment and suitable training are essential to reduce risks when managing collision scenes. Police forces, like all employers, must ensure that foreseeable risks are properly assessed and controlled so far as is reasonably practicable.

## Key Learning Points

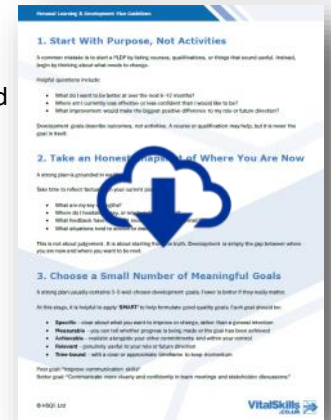
- Ensure risk assessments for collision response are suitable, sufficient and regularly reviewed.
- Provide appropriate traffic management equipment for high-speed and low-visibility environments.
- Deliver robust information, instruction and training to officers managing live traffic.
- Act on sector-wide safety recommendations and formally integrate them into local procedures.
- Recognise that public-facing emergency work still falls within core health and safety duties.

Free Downloadable Resources

# Personal Learning and Development Planning

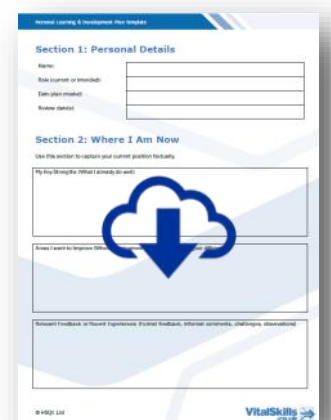
## Personal Development Plan Guidance

Guidelines on how to complete your Personal Learning and Development Plan.



## Personal Development Plan Template

An editable template for you to download and keep.



## Behind the Scenes: Independent Assurance in Action

Something that largely happens behind the scenes—out of sight for most learners—is that our approval bodies carry out regular quality assurance checks to ensure standards are being maintained.

We recently underwent such a virtual visit from Institute of Sustainability and Environmental Professionals (ISEP).

The purpose of these visits is straightforward but important: to verify that training providers are operating to the required professional standards and that learners are receiving high-quality, robust training.

Quality shouldn't be something you prepare for when an audit is scheduled—it should be built into how you operate every day. When that's the case, external assurance becomes confirmation, not concern.

For some organisations, these visits can feel daunting. The stakes are high—failure could result in approval being withdrawn and the inability to deliver accredited courses.

Our perspective is different. We welcome them.

They give us the opportunity to open up our systems, processes, and delivery to independent scrutiny from a competent external body. More than that, they act as a valuable health check and a key part of our commitment to continual improvement.

We're pleased to report that, once again, the outcome was very positive—no non-conformities, no observations, and no recommendations for improvement.



*Our ISEP-approved tutor team: Alice (Business Operations Director), Alex (Continual Improvement Director) and John (Chairman) during the assessment. Other members of the our team joined remotely.*

Find out more about our ISEP approved courses at:  
[https://hsqe.co.uk/courses/?swoof=1&product\\_cat=isep-courses](https://hsqe.co.uk/courses/?swoof=1&product_cat=isep-courses)



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# Police force fined after officers burned in riot training exercise

## Summary

A police force has been fined £60,000 after four officers sustained burns during a riot training exercise involving petrol bombs at a specialist training facility.



## What Happened

On 2 February 2021, officers took part in a simulated public disorder exercise at a training site in Rotherham. As part of the drill, officers wearing flame-retardant personal protective equipment (PPE) were required to face petrol bombs thrown by colleagues. During the exercise, four of the 13 participating officers suffered burns to their lower bodies. Three required hospital treatment. Although all four have since returned to work, the injuries resulted in permanent scarring and lasting psychological harm.

## The Investigation

An investigation by the Health and Safety Executive (HSE) found that the officers had been exposed to significant and avoidable risks.

The investigation identified several failings, including:

- A failure to properly plan and risk assess the training exercise.
- Inadequate information provided to officers regarding the lifespan, care and inspection of flame-retardant PPE, to ensure it offered effective protection.
- A failure to carry out a suitable and sufficient risk assessment covering both the production and deployment of petrol bombs during the exercise.
- A failure to implement safe systems of work to control foreseeable risks associated with petrol reception training.

The HSE concluded that appropriate controls should have been identified and implemented as part of the force's risk assessment process.

## The Outcome

Derbyshire Constabulary pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974. The force was fined £60,000 and ordered to pay £9,470 in costs.

After the hearing, an HSE inspector stated that while policing carries inherent risks, high-risk training activities must be planned and controlled with the same care and professionalism expected in any other workplace. The inspector emphasised that the risks created by the exercise should have been properly identified and appropriately controlled.

## Additional Context

Section 2(1) of the Health and Safety at Work etc. Act 1974 places a duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees.

This case highlights that training designed to replicate hazardous scenarios must be subject to the same rigorous planning, risk assessment and control measures as operational activities. The adequacy, maintenance and inspection of specialist PPE is a critical component of that control framework.

## Key Learning Points

- High-risk training must be risk assessed with the same rigour as real-world operations.
- Specialist PPE requires clear guidance on lifespan, inspection and maintenance to ensure continued protection.
- The creation of simulated hazards (such as petrol bombs) must be subject to detailed planning and control measures.
- Safe systems of work must address foreseeable risks, even within controlled training environments.
- Employers remain legally responsible for protecting employees during training activities.



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## Workers exposed to harmful vibration risks

### Summary

A metal fabrication company was fined after multiple employees developed vibration-related illnesses linked to their work activities.

### What Happened

The Health and Safety Executive (HSE) became aware in June 2024 of three reports of vibration-related illness among employees at a metal fabrication business operating from Immingham Docks.

An investigation was launched, during which an Improvement Notice was issued due to ongoing risks. Inspectors later identified three additional employees meeting the reporting threshold, with a seventh case reported by the company later that year.

Employees described significant impacts on their daily lives. Some experienced finger blanching during routine tasks such as mowing the lawn, while others reported numbness, loss of grip, and disrupted sleep due to symptoms affecting their hands.

### The Investigation

The investigation found that the company had failed to:

- Carry out suitable and sufficient risk assessments for vibration exposure
- Implement effective organisational and technical controls to reduce exposure
- Provide appropriate health surveillance for employees at risk

- Ensure employees received adequate information, instruction, and training

Although a new health and safety manager had been appointed in 2022 and had begun addressing vibration risks, employees had already been significantly exposed by that stage.

### 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 £8,061.70 in costs.

### Additional Context

Exposure to vibration, particularly from hand-held tools, can lead to conditions such as Hand-Arm Vibration Syndrome (HAVS). These conditions can cause permanent damage, affecting blood vessels, nerves, and joints.

HSE guidance stresses the need for employers to assess vibration risks properly and implement controls to reduce exposure to as low as reasonably practicable.

### Key Learning Points

- Act early, not reactively: Waiting until symptoms appear means the harm may already be permanent
- Risk assessment is fundamental: Vibration exposure must be properly assessed and regularly reviewed
- Control the source of risk: Use lower-vibration tools, maintain equipment, and limit exposure time
- Health surveillance matters: Early detection through surveillance can prevent progression of illness
- Training and awareness are essential: Workers must understand the risks and how to minimise exposure

# Worker fell from ladder during staircase works

## Summary

A construction company has been fined after a worker sustained serious injuries when he fell from a stepladder during renovation works at a property in London.

## What Happened

On 5 August 2021, a worker was involved in refurbishment works to convert an existing domestic property and a former factory building into a single dwelling.

As part of the project, a new concrete staircase was being constructed between the ground and first floors.

Temporary timber formwork was required to create the staircase mould.

The worker, along with two colleagues, had been instructed to build the formwork. While standing on the top of a stepladder and using a gas-powered nail gun, he fell approximately 1.65 metres to the floor below.

He sustained multiple serious injuries, including crush injuries to both elbows requiring several surgeries, a fractured forearm, dislocated wrists, and injuries to his right leg and left knee.

## The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to implement a safe system of work for working at height during the construction of the staircase.

The investigation also identified wider failings in the management of work at height on site, including:

- Inadequate edge protection
- Incorrectly assembled tower scaffolds
- Staircases without edge protection
- Uncontrolled use of ladders

These failings continued despite a previous HSE visit in July 2021, during which a Prohibition Notice had been served for unsafe work at height.

## 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 £4,101 in costs.

## Additional Context

Working at height is one of the leading causes of workplace injury and death. In many cases, the risks are entirely preventable through proper planning, appropriate equipment selection, and effective supervision. In this case, the continued unsafe practices following regulatory intervention significantly increased the risk.

## Key Learning Points

- Work at height must be properly planned and risk assessed.
- Ladders should only be used where they are suitable and the risk is low.
- Temporary works (such as formwork) require the same level of control as permanent structures.
- Prohibition Notices must be treated as a clear warning sign of systemic failure.
- Effective supervision is critical in managing construction site risks.



## More Information

HSE guidance can be viewed at:

<https://www.hse.gov.uk/construction/faq-height.htm>

# RIDDOR reform: HSE launches consultation on future of incident reporting

## Summary

The Health and Safety Executive has launched a public consultation on potential changes to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), inviting input from businesses, employers, and health professionals across Great Britain.

## Background

RIDDOR underpins how work-related injuries, occupational diseases, and dangerous occurrences are reported in Great Britain. The data collected plays a central role in identifying trends, targeting regulatory activity, and shaping workplace health and safety policy.

The consultation represents an opportunity to modernise the framework to better reflect today's working environments, while also addressing concerns around complexity and administrative burden.

## What is being Proposed

### Legislative changes

The consultation includes proposals to:

- Clarify definitions within RIDDOR where existing terminology is considered unclear or open to interpretation
- Update the list of dangerous occurrences to better reflect modern workplace risks
- Revise the list of reportable occupational diseases, including reintroducing previously removed conditions and adding new ones

- Broaden the range of professionals able to diagnose reportable occupational diseases, extending beyond doctors registered with the General Medical Council to other qualified health practitioners

### Non-legislative changes

HSE is also seeking views on:

- Simplifying the online reporting system to improve usability
- Reducing both under-reporting and over-reporting, which have been longstanding challenges for duty holders and the regulator

## Why it Matters

Accurate and consistent reporting is fundamental to effective risk management at a national level. Poor-quality data — whether due to under-reporting or unnecessary reporting — can distort the understanding of workplace risks and limit the effectiveness of regulatory interventions.

The proposed changes aim to strike a balance between maintaining robust protections for workers and reducing unnecessary administrative demands on businesses.

## Timeline

The consultation closes on 30 June 2026.

## More Information

Further details, including the full consultation document and how to respond, are available via the HSE consultation page: <https://consultations.hse.gov.uk/hse/proposals-riddor-2013/>

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## Garden bird feeding warning: well-meaning habits may harm wildlife

### Summary

New guidance suggests that feeding garden birds during warmer months could increase the spread of disease, contributing to significant declines in some species.

### Background

The Royal Society for the Protection of Birds (RSPB) has issued updated advice urging households to reconsider year-round bird feeding. While feeding birds is a popular and well-intentioned activity across the UK, the charity warns that it may inadvertently be causing harm under certain conditions.

### What's the Concern?

At the centre of the issue is a disease known as Trichomonosis, a parasitic infection affecting the mouth, throat and upper digestive tract of birds. Infected birds can struggle to eat, drink and breathe, and the disease is often fatal.

The infection spreads easily at feeding sites:

- Birds contaminate feeders with saliva and droppings
- Other birds ingest the parasite when feeding
- Adult birds can pass the infection directly to chicks

Busy feeders—particularly in warm weather—can therefore become concentrated transmission points.

### Impact on Bird Populations

The consequences have been significant for some species. The Greenfinch, once a common garden visitor, has seen a dramatic population decline of around two million birds and is

now on the UK red list of conservation concern.

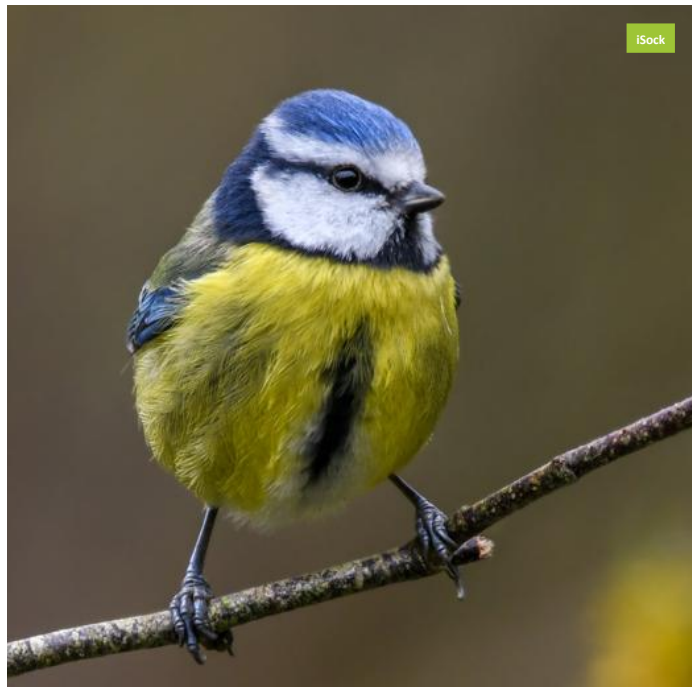
Survey data from the RSPB's long-running Big Garden Birdwatch highlights this decline, with greenfinches falling sharply in rankings over time.

### Scale of Feeding in the UK

Bird feeding is widespread:

- Over 16 million UK households regularly feed birds
- There is approximately one feeder for every nine birds
- Annual spending on bird food is estimated at £380 million

This scale means even small risks can have large cumulative impacts.



Blue tit

### Updated Advice: "Feed Seasonally, Feed Safely"

The RSPB now recommends a more cautious, seasonal approach:

- Avoid routine feeding between May and October, when disease risk is higher
- If feeding, provide only small quantities (enough for one to two days)
- Clean feeders at least weekly
- Move feeders regularly to prevent build-up of contaminated debris
- Provide water only if it can be changed daily and kept clean
- Avoid flat feeding surfaces, where contamination accumulates more easily

The organisation has also moved away from promoting traditional bird tables due to hygiene concerns.

### Why This Matters

This issue highlights a broader principle: well-intentioned actions can introduce unintended risks if not managed carefully.

Concentrating wildlife in artificial feeding areas changes natural behaviours and can amplify disease transmission—particularly when hygiene controls are not consistently applied.

### More info

RSPB guidance on feeding birds safely:

<https://www.rspb.org.uk>

Big Garden Birdwatch results:

<https://www.rspb.org.uk/get-involved/activities/birdwatch>

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