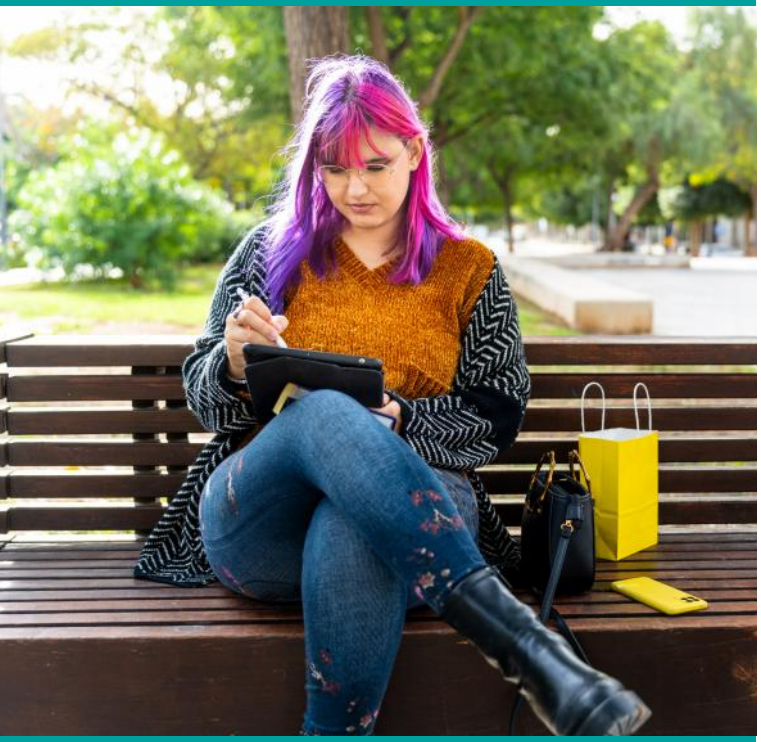
Worker suffered amputation after being crushed by concrete blocks



Summary

A vehicle maintenance company has been fined after a worker suffered life-changing injuries when one-tonne concrete blocks toppled inside an HGV trailer and crushed his legs.

What Happened

On 14 December 2023, a 35-year-old worker was inside an HGV box trailer while it was being loaded with one-tonne concrete blocks in preparation for a Driver and Vehicle Standards Agency (DVSA) brake test.

He was inside the trailer with a colleague while a third worker used a forklift truck to load the blocks. During the loading operation, the forklift truck nudged a stack of blocks already inside the trailer, causing them to topple onto the worker's legs.

The injuries were extremely serious. His left foot and lower leg later had to be amputated, and he also sustained serious injuries to his right leg. The source material also states that he was dismissed from his job after the incident.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to take appropriate precautions to segregate workers from moving vehicles on site. HSE also identified that the forklift truck driver had not been provided with training and had not been authorised to operate forklift trucks.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act. 1974.
It was fined £30,000 and ordered to pay £4,325 in costs.

Key Learning Points

- Workers should be segregated from moving vehicles and loading operations wherever possible.
- Loading activities should be properly planned and controlled to prevent loads from becoming unstable.
- Forklift truck operators should receive appropriate training and formal authorisation before using such equipment.
- Risk assessments should address workplace transport hazards and the interaction between vehicles and pedestrians.
- Employers should ensure that safe systems of work are in place and followed consistently.

More Information

Health and Safety Executive (HSE) guidance on workplace transport is available on the HSE website at:
https://www.hse.gov.uk/workplacetransport/

Apprentice injured by metal cutting guillotine

Summary

A metal fabrication company has been fined after a 17-year-old apprentice suffered a crush injury to their thumb while using a metal cutting guillotine during training.

What Happened

On 8 November 2024, the apprentice was cutting sheet metal in preparation for welding practice as part of their apprenticeship training.

The work was taking place in a dedicated apprentice training workshop, where first-year apprentices learn and practise metal fabrication techniques before progressing into the main manufacturing areas in later years of their apprenticeship. After making several successful cuts, the apprentice's thumb came into contact with the machine's clamps on the final cut, causing a crush injury.

The Investigation

The Health and Safety Executive (HSE) investigation identified, from documents provided by the company before an on-site visit, that a large gap in the bed of the guillotine allowed access to dangerous parts of the machine.

HSE found that the company had failed to identify this risk, even after the incident had occurred.

A Prohibition Notice was served remotely to control the ongoing risk. When HSE inspectors later attended the site, they identified further issues with the guillotine that required immediate action.

A wider inspection of the apprentice training workshop also revealed additional failings, including access to live electrical parts, further instances of unguarded dangerous machinery, and weaknesses in the system for inspecting workshop equipment.

The Outcome

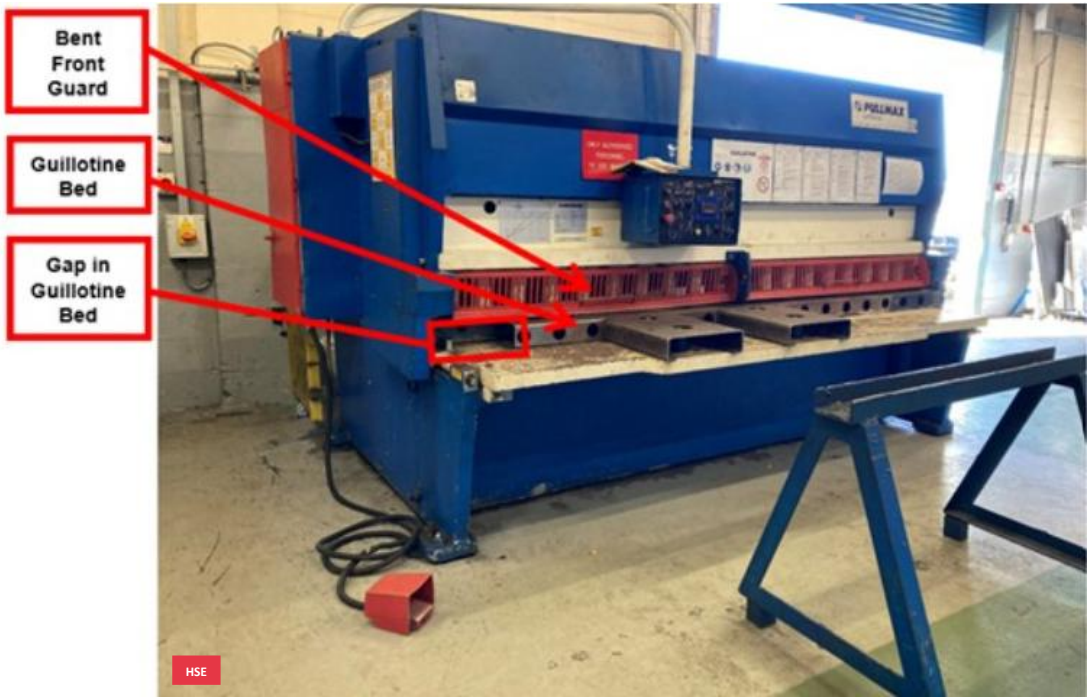
The company pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998. It was fined £140,000 and ordered to pay costs of £5,013, along with a Victim Surcharge of £2,000.

Additional Context

HSE guidance highlights the need to prevent access to dangerous parts of machinery and to properly manage risks for young people in training.

Young workers are often at greater risk of injury, particularly during the first six months of a job, because they may be unfamiliar with workplace hazards and less experienced in recognising risk.

Following the case, an HSE inspector said that employers must take particular care to assess risks for young people and apprentices, and that effective guarding would have prevented this injury.



Key Learning Points

- Machinery used by apprentices and young workers should be effectively guarded so dangerous parts cannot be reached.
- Risk assessments should give particular attention to the needs and vulnerabilities of young people in training.
- An incident should trigger an immediate review of equipment safety to ensure underlying hazards are properly identified and addressed.
- Workshops should be subject to robust inspection and maintenance arrangements to identify unsafe machinery and other hazards, including electrical risks.

More Information

Further information is available from the HSE on young people at work: https://www.hse.gov.uk/young-workers/index.htm

Teenage labourer died after falling through inadequately covered shaft

Summary

A construction company has been fined after a 19-year-old labourer died when he fell through an inadequately covered ventilation shaft while working on a building site.

What Happened

The incident happened on 5 July 2023 at a block of flats under construction in London. The 19-year-old was helping to dismantle scaffolding on the 12th-floor roof garden area.
As he stepped onto what appeared to be a covered ventilation shaft, the covering gave way beneath him. He fell six floors and sustained fatal injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the ventilation shaft had been covered only by a sheet of plasterboard and roofing foam.

HSE also found that routine inspections of the building did not include the roof garden area. As a result, the inadequate covering was not identified and the scaffolding team had not been warned about the danger.

The Outcome

The construction company pleaded guilty to breaching Regulation 4(1) of the Work at Height Regulations 2005.
It was fined £42,200, ordered to pay a £2,000 surcharge and £5,000 in costs.

Additional Context

HSE guidance on working at height states that work should be planned properly and, where possible, carried out from the ground. Where work at height cannot be avoided, employers must ensure workers can safely access and leave the work area.

The guidance also makes clear that equipment used for work at height must be suitable, stable, strong enough for the task, and properly maintained. Employers and those in control of such work must ensure it is appropriately planned, supervised and carried out by competent people.

The HSE inspector said after the prosecution "Falls from height are one of the biggest causes of workplace fatalities and major injuries. This was a wholly avoidable incident that led to the death of a young man.

Key Learning Points

- Openings, shafts and fragile coverings must be properly protected and clearly identified.
- Inspection regimes must cover all relevant work areas, including less frequently accessed locations such as roof gardens and roof-level spaces.
- Teams brought in for specific tasks, such as scaffold dismantling, must be made aware of any site-specific hazards before work begins.
- Work at height should only be undertaken where risks have been properly assessed and effective controls are in place.

More Information

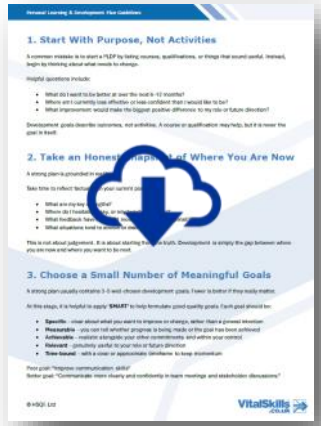
More information on working at height can be found on the HSE website at:
https://www.hse.gov.uk/work-at-height/index.htm

Free Downloadable Resources

Personal Learning and Development Planning

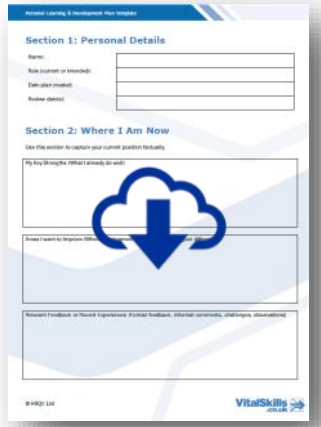
Personal Development Plan Guidance

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



Personal Development Plan Template

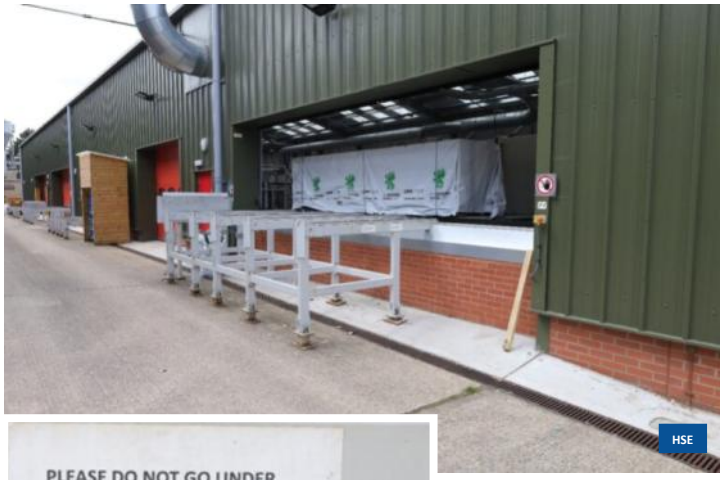
An editable template for you to download and keep.



Worker was crushed to death by timber pallet

Summary

A major building materials company has been fined after a worker died when he was crushed by a moving pallet of timber weighing around three tonnes.



What Happened

A labourer had been removing plastic packaging from pallets of timber before they were processed at a sawmill.

On 22 May 2024, he climbed inside the framework of a conveyor to access some of the packaging. Another operative, who could not see him from where he was positioned, started the conveyor. This caused the timber pack to move forwards and strike him.

When the operative saw that the timber pack was not moving as expected, he reversed the conveyor before changing its direction. This caused the pack to move forwards again, striking the worker for a second time. He sustained catastrophic crush injuries and died at the scene.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had already identified that employees were entering the danger zone within the conveyor. Warning signage had been placed on the machinery telling employees not to do so.

However, CCTV analysis showed that between 14 April and 23 May 2024, operatives entered the conveyor framework on 19 separate occasions.
Although stickers had been applied to the conveyor in an attempt to discourage the practice, HSE found that no further effective action had been taken to prevent access before the fatal 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 £2.2 million and ordered to pay costs of £9,929.

Additional Context

Following the incident, a number of measures were introduced to reduce the risk. These included guarding the conveyor to prevent access, changing the system of work so that pallets were unwrapped before being placed on the conveyor, and installing additional CCTV to improve visibility for operators. The case also highlights the continuing risks associated with sawmilling, which remains a high-risk industry despite improvements in health and safety standards over recent years.

HSE guidance makes clear that employers must prevent access to dangerous parts of machinery during normal operation, including when workers may be tempted to carry out adjustments, clear blockages, or deal with packaging and other consumables.

Key Learning Points

- Identify unsafe routine practices early and act decisively when they are found.
- Warning signs and stickers on their own are rarely enough to control serious machinery risks.
- Preventing access to dangerous parts of machinery should rely on physical safeguards, not just instructions.
- Systems of work should be designed to remove the need for employees to enter danger zones wherever possible.
- Operators must have full visibility of machinery and surrounding work areas before starting or reversing equipment.

More Information

HSE guidance on health and safety in sawmilling is available from the HSE website at:
https://www.hse.gov.uk/pubns/books/hsg172.htm

Resident choked after incorrect food preparation at care home

Summary

A care provider has been fined after a resident with known swallowing difficulties died when food was not prepared in line with his prescribed dietary requirements.

What Happened

A resident, who had recently been admitted to a care home, had a well-documented history of dysphagia (difficulty swallowing) and had been assessed as requiring a modified diet. This included food prepared to a specific texture and close supervision during meals due to a high risk of choking. During lunch, the resident was served a meal which had not been prepared in accordance with the required standard. While eating, he began to choke. Staff responded immediately, administering first aid and calling emergency services. He was later pronounced dead at hospital.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the care provider did not have a sufficiently robust system in place to ensure that texture-modified meals were consistently prepared and served correctly. Although staff had received training and a system existed for providing modified diets, it failed on this occasion. This breakdown resulted in unsafe food being served.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and was fined £16,000.

Additional Context

Dysphagia significantly increases the risk of choking, particularly in care settings where residents may rely entirely on staff to prepare and provide safe meals. The International Dysphagia Diet Standardisation Initiative (IDDSI) framework provides guidance on food textures to reduce this risk. Where individuals are identified as requiring modified diets, strict adherence to preparation standards and supervision requirements is essential. Even where systems and training are in place, failures in implementation can have fatal consequences.

Key Learning Points

- Dietary requirements must be treated as critical controls – Texture-modified diets are safety-critical, not optional adjustments.
- Systems must be fail-safe, not just available – Having procedures and training is insufficient if they do not work reliably in practice.
- Consistency at every mealtime is essential – Risks arise from single-point failures in routine activities.
- Supervision requirements must be followed – Identified behavioural risks (e.g. rapid eating) must be actively managed.
- Verification checks are vital – Food preparation and serving processes should include checks to confirm compliance before meals are provided.
- Vulnerable individuals rely entirely on systems – In care environments, residents are dependent on staff to manage risks on their behalf.

More Information

HSE guidance can be accessed at:
https://www.hse.gov.uk/pubns/books/hsg220.htm

Worker's leg amputated after unloading incident

Summary

A flower supplier has been fined after a worker suffered life-changing injuries during a manual unloading operation at a processing facility. The incident ultimately resulted in a through-knee amputation.

What Happened

A worker was helping to manually unload cargo from a delivery trailer during a busy period ahead of Valentine's Day. Some of the cargo had become stuck, and he and two colleagues attempted to free it.

As part of this process, he stepped onto a roller deck where there was a gap. When the cargo was released, a skid slid from the trailer onto the roller deck and struck his left leg, which had become trapped in the gap. The worker sustained very serious injuries. Despite medical treatment, these injuries later resulted in a through-knee amputation.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to ensure employees were safe when unloading aircraft skids from delivery vehicles in the intake area.

Workers were required to physically intervene when skids became stuck, exposing them to the risk of being struck by moving loads. The investigation also found that there was a 10cm gap in the roller deck that had not been identified or addressed, creating a risk of employees stepping into it.

The Outcome

The company pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974. It was fined £134,000 and ordered to pay £4,908 in costs.

Additional Context

The injured worker was 60 years old at the time of the incident. The injuries have had a profound impact on his life, leaving him reliant on a wheelchair and on the care of his wife. He has also been unable to continue riding motorcycles, which had been an important pastime for him.

HSE said employers must put in place suitable arrangements to manage health and safety, including effective risk control systems and safe systems of work that are followed in practice.

Key Learning Points

- Manual intervention in loading and unloading activities can expose workers to serious risks if moving loads are not properly controlled.
- Gaps, openings and other physical hazards in work equipment or work areas should be identified through suitable risk assessment and addressed promptly.
- Safe systems of work should not rely on workers placing themselves in danger to free stuck items or restore operations.
- Peak business periods can increase operational pressure, but this must not lead to unsafe practices being accepted.

Gap in roller deck pre-accident

Ride-on mower overturned at churchyard bank

Summary

A local authority has been fined after a worker was injured when a ride-on mower overturned in a churchyard and fell more than two metres onto the road and footpath below.

What Happened

The incident took place while an employee was carrying out routine maintenance in a closed graveyard. The worker was using a ride-on mower when the machine slid down a steep bank towards a retaining wall.

Both the mower and the worker went over the wall and fell around 2.3 metres onto the pavement and road below. The employee sustained injuries including cracked ribs.

The Investigation

The Health and Safety Executive (HSE) investigated the incident and identified a number of failings. It found that there had not been a suitable and sufficient assessment of the risks involved in using ride-on mowers on banks and slopes. It also found that workers had not been given adequate information, instruction or training on using this type of machinery near slopes and banks. In addition, there were no measures in place at the retaining wall to prevent a fall from height that could cause injury.

The Outcome

The organisation pleaded guilty to breaching Section 2(1) and Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £50,000 and ordered to pay £5,138.85 in costs, together with a victim surcharge of £2,000.

Additional Context

Guidance published by the British Association of Landscape Industries (BALI), which sets out measures employers should take to assess and control risks when working on or near slopes and banks.

The judge found that the organisation had failed to meet these industry standards and was therefore highly culpable, having fallen well short of what was expected.

The case also highlights that the risks associated with grounds maintenance are not limited to the machinery itself. The surrounding environment, including steep gradients, retaining walls and drops to areas used by the public, must also be considered.

Key Learning Points

- Risk assessments must properly consider the suitability of ride-on mowers for use on slopes and banks.
- Employees should receive adequate information, instruction and training on operating machinery in higher-risk terrain.
- Physical measures may be needed where there is a risk of machinery or workers falling from height.
- Employers should take account of relevant industry guidance when determining appropriate control measures.
- Routine maintenance activities can still involve serious risks if site-specific hazards are not properly managed.

More Information

The BALI guidance can be accessed at:
https://www.bali.org.uk/help-and-advice/documents/slopes-code-of-practice-document/bali-slopes-guidance-a4-28pp.pdf

Image taken on the day of the incident

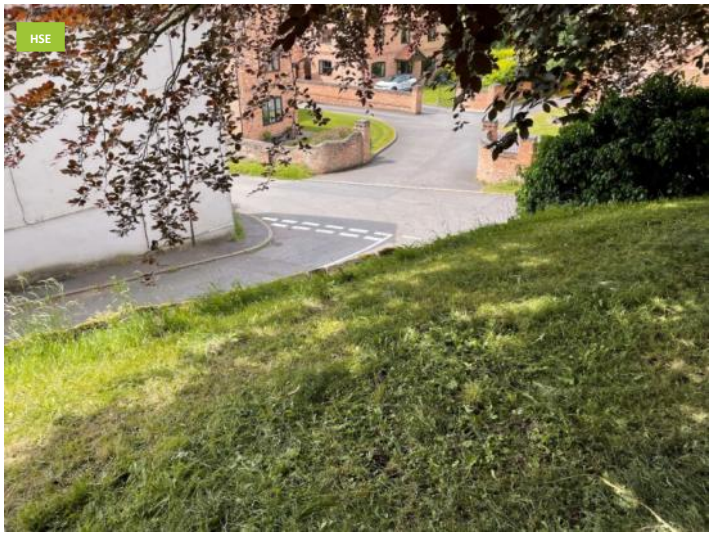


Image taken from the Church Yard, set back from the slope, looking down onto the junction

Company fined after repeated welfare failings found across multiple construction sites

Summary

A construction company has been fined after the Health and Safety Executive (HSE) identified repeated failures to provide adequate welfare facilities at construction sites across the West Midlands. The case followed a 2024 inspection that found basic legal requirements had not been met, despite earlier enforcement action and advice.

What Happened

An HSE inspection in April 2024 at a construction site in Telford found welfare failings relating to inadequate washing and rest facilities for workers. The issues identified included the absence of hot or warm water in the toilets and a lack of suitable rest facilities. As a result, HSE served two improvement notices requiring the company to take action to comply with the law. The investigation also found that this was not an isolated incident. On three previous occasions, the company had been found to be in breach of the same legislation at other construction sites in the region.

The Investigation

The HSE investigation found that the company had repeatedly failed to meet its duties under the Construction (Design and Management) Regulations 2015, despite earlier enforcement action and advice from inspectors.

HSE identified a pattern of sub-standard welfare provision across four different construction sites. The failings related to legal requirements placed on principal contractors to provide suitable welfare arrangements for workers.

These requirements include:

- a supply of clean hot and cold, or warm, water for washing
- rest facilities with an adequate number of tables and seating
- suitable arrangements for workers to prepare and eat meals

The Outcome

The company pleaded guilty to breaches of Regulation 13(4)(c) of the Construction (Design and Management) Regulations 2015. It was fined £15,858 and ordered to pay £3,858 in costs.

Inadequate welfare facilities

More Information

Further guidance is available from the HSE on construction welfare provision at:
https://www.hse.gov.uk/construction/healthrisks/welfare/index.htm

Workers lost fingers in separate machinery incidents

Summary

A plastic products manufacturer has been fined after two workers suffered serious finger injuries in separate machinery incidents within just ten days. Both incidents were linked to unsafe machinery and failures in guarding, training, and risk control.

What Happened

The first incident took place in August 2024 when a worker attempted to clear a blockage on a sanding machine. She reached into a ventilation port and her hand came into contact with a large rotating metal disc, causing severe injuries to the fingers on her right hand. One finger had to be amputated and another was so badly damaged that it would also need to be removed.

Ten days later, a second worker suffered serious injuries while using a table saw to cut small strips of plastic. His left hand came into contact with the blade, resulting in the loss of part of one finger and further surgery to remove the top of another finger.

The Investigation

The Health and Safety Executive (HSE) investigation found that adequate guards had not been fitted to machinery, leaving dangerous moving parts easily accessible. In relation to the sanding machine, the guarding arrangements were inadequate and allowed access to hazardous parts.

The investigation also found that training for use of the table saw was insufficient, there were no safe systems of work in place for cutting small materials, and the company had failed to carry out a suitable and sufficient risk assessment for the tasks being undertaken.

The Outcome

The company pleaded guilty to health and safety offences and was fined £16,000. It was also ordered to pay £6,534 in costs.

Additional Context

The two incidents were unrelated, but both happened within a short period of time and involved workers coming into contact with dangerous parts of machinery. The case highlights the importance of ensuring that machinery is properly guarded, that workers are adequately trained, and that suitable safe systems of work and risk assessments are in place.

Each year, a number of workplace accidents involving machinery and work equipment result in serious injury or death. These incidents continue to demonstrate the consequences of poor control measures around dangerous equipment.

Key Learning Points

- Machinery must be properly guarded so that dangerous parts cannot be reached during normal work or when dealing with blockages or minor interruptions.
- Employers should ensure that safe systems of work are in place for higher-risk tasks, including work involving small materials and cutting equipment.
- Training must be sufficient, task-specific, and supported by supervision where necessary.
- Risk assessments must be suitable and sufficient, reflecting the actual work being carried out and the hazards presented by the equipment.
- Repeated serious incidents in a short timeframe can point to wider weaknesses in machinery safety management and operational control.

More Information

HSE guidance on work equipment and machinery:
Work equipment and machinery can be accessed at:
https://www.hse.gov.uk/pubns/puwerind.htm

Worker broke leg after fall from compost screening machine

Summary

A green waste recycling company has been fined after an employee broke his leg while trying to clear a blockage from a compost screening machine. The incident happened when he climbed onto the machine and fell from an unguarded area at height.

What Happened

On 16 February 2024, an employee at a green waste recycling site in West Sussex climbed onto a compost screening machine to clear a blockage from the fan housing.

The machine was suspended at height within a large barn and did not have adequate measures in place to prevent falls. As the worker climbed onto the machine, he slipped and trapped his left leg between the machine and its frame.

The force of the incident, together with the lack of guardrails around the fan housing, caused him to fall backwards onto the gantry. He struck his head on a handrail while his leg remained trapped. He suffered a broken leg and required surgery to insert a metal plate and screws.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to assess the risks associated with cleaning the machine, including the risk of falling from height from the unguarded edges around the fan housing.

HSE also found that the company's standard operating procedure did not provide employees with instructions on how to safely clean and unblock the fan housing.

The investigation further identified a failure to prevent access to dangerous parts of the machine. In particular, the interlocked gate did not prevent employee access during the cleaning process for the rotating discs used to break down larger clumps of compost.

The Outcome

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

It was fined £14,000 and ordered to pay £6,500 in costs.

Additional Context

HSE guidance on working at height states that employers should carry out as much work as possible from ground level and ensure that workers can safely access and leave any area where work at height is required.

It also states that equipment used for work at height must be suitable, stable and strong enough for the task, and properly maintained. Work at height activities should be properly planned, supervised and carried out by competent people using appropriate equipment.

Following HSE's intervention, the company introduced new guarded working platforms around the fan housing and over the rotating discs.

Key Learning Points

- Work at height should be avoided where possible and completed from ground level if it is reasonably practicable to do so.
- Risk assessments must consider routine and non-routine tasks, including cleaning and unblocking machinery.
- Machinery should have effective guarding and controls to prevent access to dangerous parts during cleaning and maintenance.
- Safe systems of work and standard operating procedures must give clear instructions for carrying out higher-risk tasks safely.
- Post-incident improvements can demonstrate that better controls were reasonably practicable all along.

More Information

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

Worker entangled in unguarded machinery

Summary

A South Yorkshire wire manufacturer has been sentenced after a worker sustained fatal injuries when he became entangled in unguarded machinery.

What Happened

On 18 November 2021, a 45-year-old employee was fatally injured at a wire manufacturing site in Penistone.

The worker became entangled in an unguarded wire drawing and recoiling machine known as a 'Gravity Block'. The machine had exposed moving parts, which were accessible while it was operating. He sustained fatal injuries as a result.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to implement effective measures to prevent access to dangerous moving parts of the wire drawing machine.

The investigation identified that a suitable and sufficient risk assessment had not been carried out. As a consequence, a safe system of work had not been properly developed or clearly communicated to the workforce.

HSE also found that recognised safety measures had not been installed. These should have included fixed closed guards, interlocking systems or pressure-sensitive mats to prevent operatives from entering the 'Gravity Block' while it was rotating.

The company had relied on verbal instruction rather than providing formal training and had not appointed a designated competent person on site. Substandard conditions were allowed to persist over a prolonged period, despite established industry standards for machinery guarding.

The Outcome

The company pleaded guilty at an early hearing to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £140,000 and ordered to pay £6,652 in costs.

Additional Context

The Provision and Use of Work Equipment Regulations 1998 (PUWER) require employers to ensure that work equipment is suitable, properly maintained and fitted with appropriate safety measures, including effective guarding of dangerous parts.

Key Learning Points

- Dangerous moving parts must be securely guarded to prevent access during operation.
- Risk assessments must be suitable and sufficient, with clear safe systems of work developed and communicated.
- Engineering controls (such as fixed guards and interlocks) should take precedence over reliance on verbal instruction.
- Formal training and the appointment of competent persons are critical in high-risk manufacturing environments.
- Allowing substandard machinery guarding to persist significantly increases the risk of fatal injury.

More Information

More information about the Provision and Use of Work Equipment Regulations 1998 (PUWER) can be accessed at: https://www.hse.gov.uk/work-equipment-machinery/puwer.htm

Worker's legs were crushed by moving production frames

Summary

A national manufacturer of building materials has been fined £633,300 after an employee's legs were crushed between one-tonne metal frames moving on a production line.

What Happened

On 22 July 2022, an employee was working at a manufacturing plant in Essex. He entered a fenced area to manually clean and inspect large metal frames used to transport heavy blocks along a trackway through the production process.

Access to the area was via an interlocked gate, which was intended to prevent frames from moving along that section of track when opened. While he was working on a stationary frame, another frame travelled into the section and struck him. His legs were crushed and pinned between the two frames. As the frames continued to move along the track, he was pushed towards adjacent machinery. One leg was broken and the other severely bruised. A colleague witnessed the incident and activated the emergency stop, preventing further injury.
The injured worker required hospital treatment, including surgery to insert a metal rod and screws. He was unable to return to work for over a year and underwent extensive physiotherapy.

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 or to prevent movement of the frames when employees entered the danger zone.

The interlocked gate did not isolate power to preceding sections of the track. As a result, a frame could still move into the cleaning area while employees were present.

The investigation also identified that several near misses had previously occurred on the same section of track in similar circumstances. These incidents had not been adequately addressed.

Furthermore, a risk assessment carried out several years before the incident had identified that additional control measures were required to reduce risk to an acceptable level. However, those measures were not implemented until after the injury occurred.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £633,300 and ordered to pay £5,583 in costs and a £2,000 victim surcharge.

Additional Context

HSE guidance on the safe use of work equipment makes clear that employers must take effective measures to prevent access to dangerous parts of machinery.

This duty extends beyond initial installation. Employers are expected to monitor the effectiveness of control measures and investigate accidents and near misses to identify weaknesses in their systems of work and implement improvements.

In this case, previous near misses on the production line had highlighted the risk, yet sufficient corrective action was not taken before a serious injury occurred.

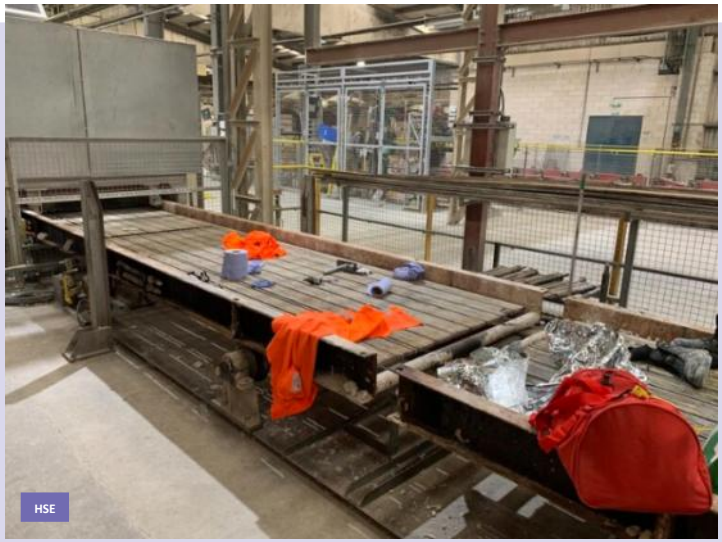
Key Learning Points

- Interlocks must provide effective isolation of all relevant energy sources.
- Guarding arrangements should prevent both access to danger zones and unexpected movement of machinery.
- Near misses must be properly investigated and acted upon.
- Risk assessments identifying additional controls must result in timely implementation.
- Monitoring and review are essential components of a functioning safety management system.

More Information

Further guidance on machinery safety and the safe use of work equipment can be found on the HSE website at:
https://www.hse.gov.uk/pubns/books/l22.htm

More information about investigating accidents and incidents can be accessed at:
https://www.hse.gov.uk/pubns/books/hsg245.htm



Contractor jailed after teenager died during demolition work

Summary

A self-employed contractor has been jailed after a 19-year-old worker fell through a garage roof during demolition works at a domestic property in Surrey and later died from his injuries.

What Happened

On 16 August 2023, a 19-year-old worker was assisting with the demolition of a garage at a domestic property in Staines-upon-Thames in preparation for an extension.

The teenager was working directly from the garage roof removing tiles and other materials when he fell through an opening. He sustained severe head injuries and was taken to hospital. He died several weeks later on 23 September 2023.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that no measures had been put in place to prevent a fall from height, despite the obvious risk. Work was carried out from the roof without scaffolding, staging, edge protection or other systems to prevent a fall through or from the structure.

During the investigation, further health and safety failings were identified, including:

- Unsafe use of a mini-digger.
- Failure to prevent members of the public from accessing the site.
- No assessment to determine whether asbestos was present before demolition began.

Corrugated concrete sheets removed during the work were later confirmed to contain asbestos cement, a material commonly found in buildings constructed before 2000. The sheets were snapped and removed by hand, exposing three other workers and potentially others on site to asbestos fibres.

The investigation concluded that there had been broader failings in the management of health and safety throughout the project.

The Outcome

The contractor pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974.

He was sentenced to 12 months' immediate imprisonment. No costs were awarded.

Additional Context

Working at height remains one of the leading causes of death and serious injury in construction. Employers and self-employed contractors have a legal duty to ensure that suitable and sufficient measures are in place to prevent falls.

Before undertaking demolition or refurbishment work, dutyholders must assess whether asbestos is present and ensure that appropriate control measures are implemented. Failure to do so can expose workers and others to significant long-term health risks.

The victim's family described the death as devastating and emphasised that it could have been avoided, expressing hope that the case serves as a warning about the consequences of ignoring health and safety responsibilities.

Key Learning Points

- Plan work at height properly – Avoid working directly from fragile or unprotected roofs. Use scaffolding, edge protection, covers or other suitable fall prevention systems.
- Carry out suitable and sufficient risk assessments – Identify hazards before work begins and implement appropriate control measures.
- Assess for asbestos before demolition – Buildings constructed before 2000 may contain asbestos. Surveys and safe systems of work are essential.
- Control site access – Prevent members of the public from entering active work areas.
- Small projects still require compliance – Domestic scale work does not remove legal duties under health and safety law.

More Information

HSE guidance on working safely at height:
https://www.hse.gov.uk/work-at-height/

HSE guidance on asbestos and demolition work:
https://www.hse.gov.uk/asbestos/

Record levels of modern slavery raise concerns over exploitation in the UK

Summary

The rising cost of living, insecure work, and advances in technology are contributing to record levels of exploitation in the UK, according to a new report from the Independent Anti-Slavery Commissioner (IASC). More than 23,000 potential victims of modern slavery were referred in 2025 — the highest number recorded and a 22% increase on the previous year. The report warns that modern slavery, people trafficking, forced labour, and sexual exploitation are becoming more widespread and increasingly difficult to detect.

Background

The report, published more than a decade after the introduction of the Modern Slavery Act 2015, brings together evidence from over 50 organisations examining how exploitation may evolve in the coming years.

Three major factors were identified as driving the increase in exploitation:

- Rising living costs
- Debt and financial hardship
- Insecure employment

The report also notes that global conflict and displacement are creating conditions that make vulnerable people easier targets for traffickers and organised criminal groups.

More than one fifth of potential victims identified in 2025 were UK nationals, making them the largest single group. Eritrean nationals were the second-largest group, followed by Vietnamese nationals.

The Independent Anti-Slavery Commissioner warned that exploitation within the UK is becoming increasingly common, particularly involving children and young people. Concerns were raised about the use of online platforms, including video games and social media, where perpetrators may build trust with vulnerable children before coercing or exploiting them. The report suggests that boys are more commonly exploited through criminal activity linked to county lines and drug gangs, while girls are more likely to face sexual exploitation. It also warns that victims are often reluctant to seek help due to fear, intimidation, or concerns about getting into trouble.

Response and Concerns

The commissioner stated that the UK's current response is not keeping pace with the scale and complexity of the threat.

Recommendations included:

- Increased funding for specialist police units
- Stronger action against organised criminal networks
- Financial penalties for businesses found to have breached anti-exploitation requirements

The Home Office said it remains committed to reviewing the modern slavery system while ensuring protections remain in place for genuine victims. It also stated that work is ongoing to reduce case backlogs and improve support arrangements.

Additional Context

The Modern Slavery Act 2015 consolidated existing offences relating to trafficking and exploitation into a single piece of legislation. It also introduced additional protections for victims and new powers to prosecute offenders.

The legislation includes a defence for victims of slavery or trafficking who have been forced to commit offences as part of their exploitation.

Key Learning Points

- Modern slavery and exploitation remain significant issues within the UK, not just internationally.
- Financial hardship and insecure work can increase vulnerability to exploitation.
- Criminal groups are increasingly using technology and digital platforms to target victims.
- Children and young people may be at particular risk of online grooming and exploitation.
- Businesses should ensure appropriate due diligence and anti-exploitation measures are in place within their operations and supply chains.
- Awareness, early intervention, and reporting remain important in helping identify and prevent exploitation.

More Information

UK Modern Slavery Guidance:
https://www.gov.uk/government/collections/modern-slavery
Modern Slavery Act 2015:
https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted
Independent Anti-Slavery Commissioner:
https://www.antislaverycommissioner.co.uk
Online Course 'Modern Slavery Awareness':
https://hsqe.co.uk/courses/modern-slavery-awareness/
Online Course 'Child Sexual Exploitation Awareness':
https://hsqe.co.uk/courses/child-sexual-exploitation-awareness/

Online safety concerns raised over social media platforms

Summary

The UK communications regulator, Ofcom, has criticised TikTok and YouTube, stating that their content recommendation systems are still “not safe enough” for children. The comments were made as part of a wider review into how major online platforms are responding to concerns about children’s online safety, harmful content, and grooming risks.

Background

Ofcom said TikTok and YouTube had not committed to making significant changes to reduce harmful content being shown to children, despite ongoing concerns about the impact of personalised content feeds and recommendation algorithms. The regulator stated that evidence suggests children can still be exposed to harmful or inappropriate material through content feeds designed to maximise engagement.
Both platforms responded by highlighting existing safety features. TikTok pointed to restrictions such as preventing direct messaging for under-16s, while YouTube referenced parental controls and time limit features for its Shorts platform.

The report also examined concerns around children accessing platforms despite minimum age requirements. Ofcom research found that many children aged between eight and 12 continue to use services officially intended for users aged 13 and above. The regulator indicated it may share concerns with the UK government regarding how effectively minimum age rules are enforced, particularly as discussions continue around potential restrictions on social media use for under-16s.

Additional Measures

Ofcom highlighted several measures being introduced by other platforms to help reduce grooming and online harm risks, including:

- stronger age verification processes,
- restrictions on adults contacting children,
- additional parental controls,
- improved privacy protections for younger users,
- and the use of artificial intelligence to identify potentially harmful conversations.

The regulator stated that it expects these measures to be implemented effectively and warned that enforcement action could follow if companies fail to comply with online safety requirements.

Key Learning Points

- Online safety concerns increasingly focus on how recommendation algorithms expose children to harmful content.
- Age verification and enforcement of minimum age requirements remain significant challenges for online platforms.
- Organisations operating digital platforms may face growing regulatory scrutiny regarding safeguarding responsibilities.
- Parental controls, privacy settings, and user education remain important tools in reducing online risks for children and young people.
- Online safety regulation is continuing to evolve, with increasing expectations around proactive prevention rather than reactive content removal.

More information

Ofcom: https://www.ofcom.org.uk

Illegal waste "super sites" identified across England

Summary

The Environment Agency (EA) has published a new watchlist identifying 117 high-priority illegal waste sites across England, including 28 large-scale "super sites" containing more than 20,000 tonnes of waste. The agency says the list is intended to improve transparency and support ongoing action against waste crime.

Background

The newly published watchlist highlights sites considered to pose significant environmental or community concerns. According to the EA, around 700 illegal waste sites are currently believed to exist across England, although only the higher-priority locations have been included on the public list. Among the sites identified is a large stockpile of contaminated soil in Cheshire estimated to contain approximately 281,000 tonnes of waste. Other locations include sites in Kent, Oxfordshire, Wigan, and Sheffield.

The waste involved varies considerably and includes household refuse, construction materials, tyres, asbestos, and contaminated soils. Some sites are alleged to be operating without the required environmental permits, while others involve large-scale dumping on privately owned land.

The EA stated that some sites are already undergoing clean-up work, while others may potentially require future intervention. However, it emphasised that it is not generally funded to clear illegal waste sites except in exceptional circumstances where serious environmental risks or impacts on local communities are identified.

Concerns remain among some local businesses and residents about the scale of illegal waste activity and the speed of enforcement action. Questions have also been raised about whether greater use should be made of recovering clean-up costs from those responsible for waste crime.

The Environment Agency said it intends to update the watchlist monthly as investigations continue. Limited detail has been published about individual sites to avoid affecting ongoing enforcement activity.

More information

Environment Agency: https://www.gov.uk/government/organisations/environment-agency

River pollution claim reaches High Court

Summary

More than 4,500 people who live or work near the rivers Wye, Lugg and Usk have joined a legal claim against one of the UK's largest chicken producers and a water company over alleged river pollution.

> The case is being viewed as significant because of the number of claimants involved, the geographical area covered, and the wider questions it raises about accountability for environmental harm.

Background

The claim alleges that pollution linked to poultry manure spreading and sewage discharges has contributed to declining river conditions, including algal blooms, odour, and impacts on fishing, recreation, businesses and local communities.

The rivers, which run along the Welsh-English border, have faced growing concern in recent years. The River Wye was rated as "unfavourable – declining" by Natural England in 2023. A later action plan identified excessive nutrients from farming and wastewater discharges, alongside climate change pressures, as contributing factors.

The companies involved reject the allegations. The poultry company has described the claim as misconceived and says river health is affected by multiple factors. The water company has described the case as misguided and says it has invested, and will continue to invest, in reducing nutrient levels.

Key Learning Points

- Businesses can face legal, financial and reputational risks where their activities are alleged to contribute to environmental harm.
- Pollution risks may arise across supply chains, not only from direct operations.
- Nutrient pollution can have serious effects on water quality, biodiversity, local communities and businesses that depend on rivers.
- Environmental controls, monitoring and accountability are increasingly important where operations interact with sensitive natural environments.

More information

BBC Website:
https://www.bbc.co.uk/news/articles/cqxl5rjw58po

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CPD Assured | £6.50-£15.00+VAT | View

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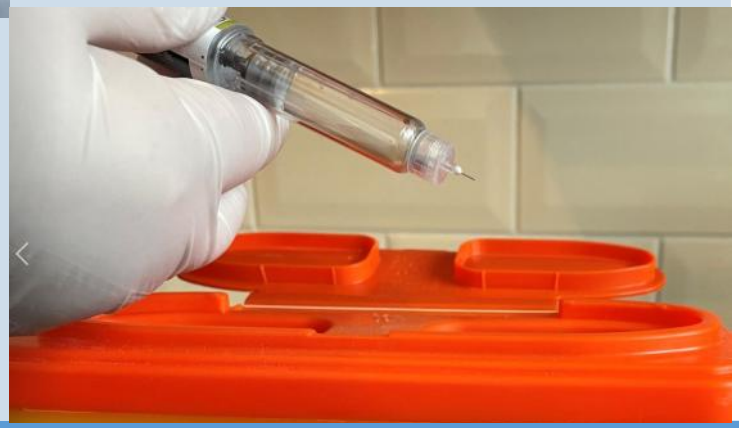

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