

Company Fined for Multiple Serious Safety Failings – How Many Can You Spot?



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HSE

Waste and Recycling Company Fined After Multiple Safety Failures

Summary

A waste and recycling company has been fined after the Health and Safety Executive (HSE) identified multiple serious health and safety failures at its recycling site, including unsafe vehicle and pedestrian movements and dangerously stacked skips that posed a risk of collapse.

What Happened

Inspectors from the HSE visited the company's waste and recycling site on 11 August 2022. During the inspection, they observed several vehicles, including tipper lorries and loading shovels, operating throughout the site.

The pedestrian entrance had been chained and padlocked, forcing workers and visitors to use the same entrance as moving vehicles. There was no effective segregation between pedestrians and vehicles, and no designated pedestrian routes or crossing points were in place.

Inspectors also found numerous skips stacked unsafely around the site. Some of the skips were damaged and deformed, increasing the risk of instability. In places, skips had been stacked three-high, creating a significant risk of collapse or falling objects. These stacks were located in areas regularly accessed by workers on foot and by vehicles.

The Investigation

The HSE found that the site's traffic management arrangements were inadequate. Although a traffic management plan existed, it was not displayed for workers or visitors and had become outdated following changes to the site's layout. As a result, it did not adequately address pedestrian movements around the site, including access routes to welfare facilities.

Following the initial inspection, HSE served a number of improvement notices requiring the company to address the identified health and safety breaches. A further visit took place 11 days later.

The investigation also established that the company had previously been subject to enforcement action. In 2019, prohibition notices had been served in relation to stockpiling activities and the risk of collapse, demonstrating that similar concerns had been raised in the past.

The Outcome

The company pleaded guilty to two offences under Section 33(1)(a) of the Health and Safety at Work etc. Act 1974 for failing to fulfil its duties under Sections 2 and 3 of the Act and exposing employees, agency workers and others on site to the risk of death or serious injury.

The company was fined £167,000 and ordered to pay costs of £16,195.



Key Learning Points

- Ensure pedestrians and vehicles are effectively segregated wherever possible.
- Maintain clearly marked pedestrian routes and crossing points.
- Regularly review and update traffic management plans to reflect changes to site layouts and operations.
- Communicate traffic management arrangements to all workers and visitors.
- Inspect skips and storage containers for damage before stacking.
- Avoid excessive stacking heights that could compromise stability.
- Keep stacked materials away from areas regularly accessed by workers.
- Promptly address findings from inspections and enforcement actions to prevent repeat breaches.



Skips were piled three-high in places, and in areas regularly accessed by workers, according to the HSE



Landscaping Company Fined After A Worker Was Struck by a Reversing Vehicle

Summary

The Health and Safety Executive (HSE) has successfully prosecuted a landscaping and civil engineering company after a worker suffered life-changing injuries when he was struck by a reversing flatbed truck at a workplace in Wolverhampton. The HSE's investigation found significant failings in the management of workplace transport, particularly the separation of pedestrians and vehicles.

What Happened

A 58-year-old employee was walking across the site when he was struck by a visiting flatbed truck that was reversing. The incident resulted in life-changing injuries, including:

- Serious head injuries.
- Damage to his eyesight.
- Significant mental and psychological trauma.

The Investigation

An investigation by the HSE found that the workplace had not been organised to allow pedestrians and vehicles to move around safely.

HSE identified several failings, including:

- No clearly defined pedestrian walkways.
- No instructions for visiting drivers on safe vehicle manoeuvring.
- Inadequate arrangements to ensure vehicles could reverse without endangering pedestrians.

The Outcome

The company was found guilty of breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £125,000 and ordered to pay £150,000 in costs.

Additional Context

Workplace transport continues to be one of the leading causes of serious workplace incidents. According to HSE, almost a quarter of all workplace transport fatalities occur during reversing manoeuvres. Many other reversing incidents also result in significant damage to vehicles, equipment and premises.

HSE advises that employers should eliminate reversing wherever reasonably practicable by introducing measures such as one-way traffic systems and drive-through loading and unloading arrangements. Where reversing cannot be avoided, routes should be designed to minimise the need to reverse and appropriate control measures should be implemented to protect pedestrians.

Key Learning Points

- Separate pedestrians and vehicles wherever reasonably practicable.
- Provide clearly marked pedestrian routes throughout the workplace.
- Implement safe traffic management systems, including one-way routes where possible.
- Eliminate or minimise reversing manoeuvres wherever reasonably practicable.
- Ensure drivers receive clear instructions on site traffic arrangements.
- Introduce suitable controls, such as trained banksmen or reversing aids, where reversing cannot be avoided.
- Regularly review workplace transport risk assessments to ensure controls remain effective.

More Information

HSE guidance can be viewed at:

<https://www.hse.gov.uk/workplacetransport/information/reversing.htm>

We have also recently released a Banksman (Traffic Marshal) Awareness online course. It can be viewed at: <https://hsqe.co.uk/courses/banksman-traffic-marshall-awareness/>



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A Reminder That Risk to Workers from Extreme Heat Must Be Managed

The Health and Safety Executive (HSE) has reminded employers that they must assess risks to the health and safety of their workers by law, including risks from extreme weather such as heatwaves. While there is no legal maximum temperature for workplaces, heat is classed as a hazard and should be treated like other hazards.

‘Simple measures’ they suggest include:

- Making sure workplace windows can be opened or closed to prevent hot air from circulating or building up.
- Using blinds or reflective film on workplace windows to shade workers from the sun.
- Placing workstations away from direct sunlight and heat sources.
- Putting insulation around hot pipes and machinery.
- Offering flexible working patterns so workers can work at cooler times of the day.
- Providing free access to drinking water.
- Relaxing dress codes if possible.
- Providing weather-appropriate personal protective equipment.
- Encouraging workers to remove personal protective equipment when resting (ideally in shaded areas) to cool off.
- Sharing information about the symptoms of heat stress and what to do if someone is affected.

Self-Employed Handyman Was Sentenced for Illegal Gas Work

Summary

A self-employed handyman was sentenced after carrying out illegal gas work at a rented property without being registered to undertake the work. An inspection identified a dangerous gas leak and several other serious defects, with the installation deemed an immediate danger to life.

Although nobody was injured, the case highlights the potentially catastrophic consequences of unqualified gas work.

What Happened

In November 2023, a self-employed handyman was hired by the landlords of a property in Birmingham to install a boiler. The tenant became suspicious after witnessing the gas work being carried out and discovered that the individual was not listed on the Gas Safe Register, despite claiming to be registered.

An inspection carried out the following month identified an immediately dangerous gas leak on the boiler pipework, along with several additional defects that posed significant safety risks.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the handyman had undertaken gas work without being competent to do so and without being registered on the Gas Safe Register, as required by law.

HSE reminds homeowners, landlords and businesses that only Gas Safe registered engineers are legally permitted to carry out gas work. All gas installations and maintenance must also comply with the relevant safety standards.

The Outcome

The individual pleaded guilty to breaching Regulation 3(3) of the Gas Safety (Installation and Use) Regulations 1998. The court imposed a 26-week suspended prison sentence and ordered the individual to pay £500 compensation to the tenant.



The leaking pipe

Key Learning Points

- Always verify that anyone carrying out gas work is registered with the Gas Safe Register before work begins.
- Landlords have a legal duty to ensure gas appliances and installations are installed and maintained safely.
- Illegal gas work can result in gas leaks, fires, explosions and carbon monoxide poisoning.
- Employees and tenants should raise concerns if they suspect gas work is being carried out by an unqualified person.
- Competence and legal compliance are essential when working on gas systems to protect lives and property.

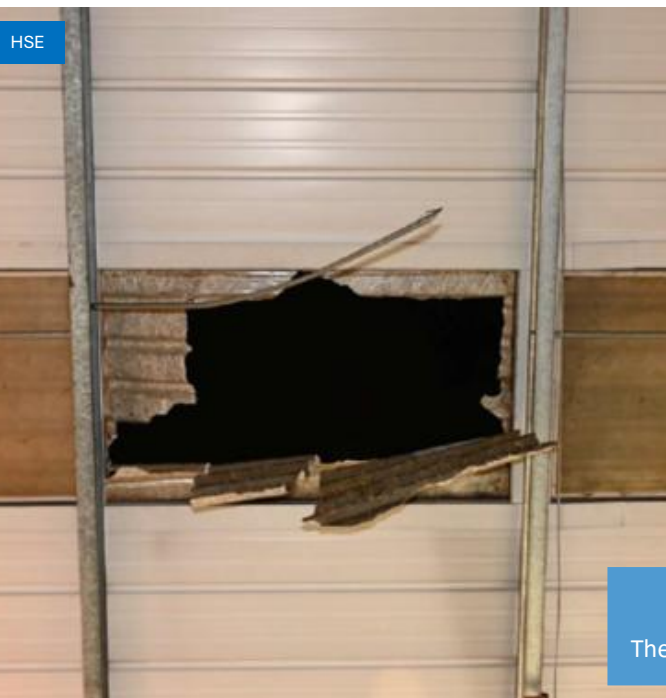


Worker Suffered Serious Injuries after Falling Through Roof Skylight

Summary

Two construction companies have been fined a combined £79,300 after a scaffolder suffered serious injuries. He fell more than six metres through a fragile roof skylight while installing temporary edge protection on a warehouse roof in West Yorkshire.

The Health and Safety Executive (HSE) found that the work had not been properly planned, managed or monitored, and that no suitable measures were in place to prevent falls from either the roof edge or through fragile roof surfaces.



HSE

What Happened

The incident occurred while a scaffolder was installing temporary scaffolding edge protection on the roof of a warehouse. As he carried materials across the roof, he stepped onto a skylight that he did not realise was a fragile surface. The skylight gave way beneath him, causing him to fall more than six metres onto the concrete floor below. The worker struck a pallet truck during the fall before landing on the warehouse floor. He sustained a broken arm, a broken leg and head lacerations.

The Investigation

HSE's investigation found that both companies responsible for the work had failed to adequately plan, manage and monitor the roofing activity. No controls had been implemented to prevent workers from falling through the roof's fragile skylights or from the roof edge. Investigators also found that the skylights were almost invisible from the roof surface, leaving workers unaware of the danger.

HSE guidance states that those responsible for roof work should, wherever possible, avoid the need to access fragile roofs. Where access is unavoidable, appropriate control measures must be implemented to protect workers from falls through fragile surfaces.

The Outcome

One company pleaded guilty to breaching Regulation 15 of the Construction (Design and Management) Regulations 2015 and was fined £26,000, with costs of £2,866. The company has since entered liquidation.

The second company pleaded guilty to breaching Regulation 13 of the Construction (Design and Management) Regulations 2015 and was fined £53,300, with costs of £3,167.

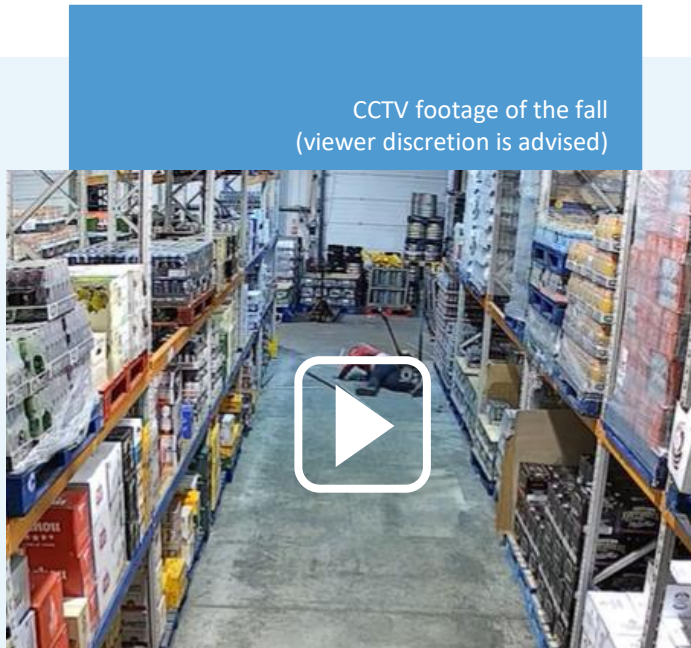
The broken roof skylight

Key Learning Points

- Plan, manage and monitor all work at height before work begins.
- Avoid access to fragile roof surfaces wherever reasonably practicable.
- Identify and clearly mark all fragile roof elements, including skylights and rooflights.
- Install suitable fall prevention or fall protection measures before roof work starts.
- Ensure workers are informed of all roof hazards and receive appropriate training and supervision.
- Regularly review site controls to ensure they remain effective throughout the work.

More Information

Further guidance is available from the HSE:
<https://www.hse.gov.uk/pubns/priced/hsg33.pdf>


CCTV footage of the fall
(viewer discretion is advised)


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Major Gas Leak was Caused by Years of Unchecked Corrosion

Summary

A company has been fined £1 million after a major gas leak at an oil refinery in Hampshire, following the partial collapse of a large steel tower. The incident resulted in the uncontrolled release of around 2,400kg of liquefied petroleum gas (LPG) over a 33-hour period, exposing workers to the risk of serious injury.

What Happened

On 8 November 2022, part of a large steel tower collapsed at the refinery, causing it to move and rupture connected pipework. This led to the release of highly flammable LPG, with around 400kg escaping within the first 30 minutes. Workers were nearby when the structure failed and were at risk from falling debris and the potential ignition of the gas. Emergency measures, including water curtains, were used to limit the spread of the flammable vapour while the affected process was isolated. It took approximately 33 hours to safely bring the incident under control.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the collapse was caused by corrosion that had developed over many years. The corrosion had been identified in 2010, but appropriate action was not taken to manage the deteriorating condition of the structure. HSE highlighted that dutyholders must ensure the integrity of plant and pipework is maintained through effective inspection, maintenance and corrosion management to prevent the loss of containment of hazardous substances.

The Outcome

The company pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £1 million and ordered to pay £12,277 in costs.

Key Learning Points

- Ensure inspection programmes identify corrosion before it becomes a structural risk.
- Promptly address known defects rather than allowing deterioration to continue.
- Maintain the integrity of plant, structures and pipework through effective maintenance.
- Regularly review asset condition as part of a formal asset integrity management system.
- Have robust emergency arrangements in place to respond quickly to any loss of containment involving hazardous substances.



More Information

Guidance on managing corrosion under insulation and maintaining plant and pipework is available at: https://www.hse.gov.uk/foi/internalops/hid_circs/technical_general/spc_tech_gen_18.htm

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Worker Suffered Double Leg Amputation After Excavator Incident

Summary

A waste management company has been prosecuted after a worker suffered life-changing injuries when he was struck and crushed by a reversing excavator at a waste management yard. Both of the worker's lower legs were later amputated.

What Happened

On 7 November 2023, a 24-year-old worker was sorting waste at a waste management yard when a 15-tonne excavator operating in the same area reversed over him.

The incident resulted in catastrophic injuries, and both of the worker's lower legs were subsequently amputated. He has been unable to return to work since the incident.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to implement suitable measures to protect workers and visitors from moving vehicles within the yard.

The investigation identified that there were inadequate arrangements to ensure the safe separation of pedestrians and vehicles. Workers were exposed to the risk of being struck by moving plant and machinery, including large vehicles that were required to reverse during site operations.

HSE highlighted that employers must organise workplaces so that pedestrians and vehicles can move around safely and that additional precautions should be considered where reversing vehicles are present.

The Outcome

The company pleaded guilty to breaching Section 2(1) and Section 3(1) of the Health and Safety at Work etc. Act 1974.

The court heard that the appropriate fine would have been £180,000, reduced to £120,000 to reflect the guilty plea.

However, as the company had entered liquidation and was unable to pay, it was ordered to pay a nominal fine of £1. No costs were awarded.

Additional Context

Workplace transport incidents remain one of the most significant causes of serious injuries and fatalities across many industries, including waste management.

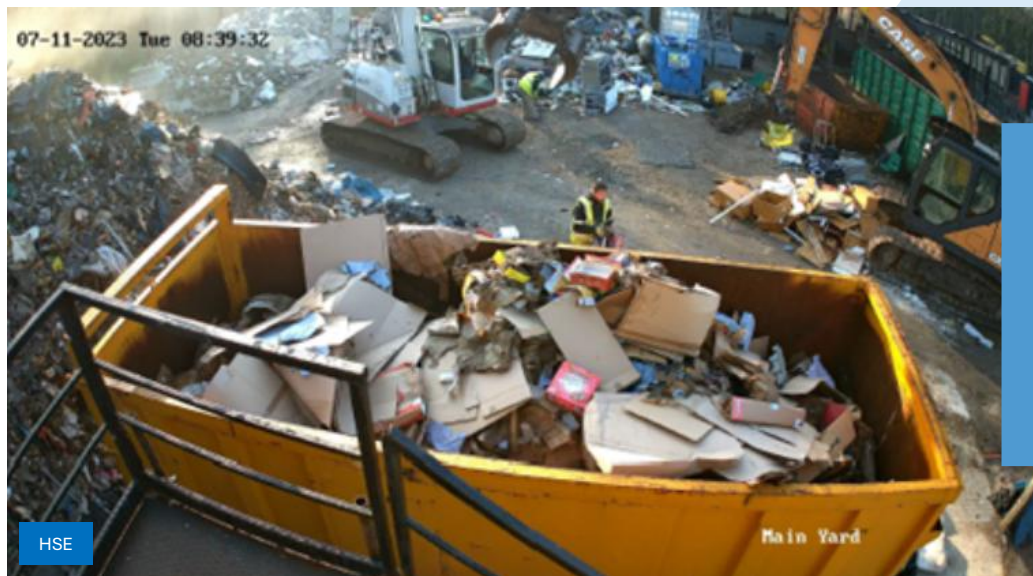
Key Learning Points

- Separate pedestrians and vehicles wherever reasonably practicable.
- Assess and control the risks associated with reversing vehicles and mobile plant.
- Implement clear traffic management arrangements across sites.
- Ensure workers understand and follow safe vehicle movement procedures.
- Regularly review workplace transport risks and site layouts.
- Take prompt action when deficiencies in traffic management arrangements are identified.

More Information

Health and Safety Executive (HSE) guidance on workplace transport safety and reversing vehicles is available via the HSE website at:

<https://www.hse.gov.uk/pubns/priced/l24.pdf>



CCTV screenshot of the waste yard prior to incident



Worker Entangled in Conveyor Machinery

Summary

A poultry and egg production company has been fined after a worker suffered serious nerve damage when his clothing became caught in conveyor machinery during a routine cleaning operation at a farm.

What Happened

On 15 October 2024, a 36-year-old employee was carrying out cleaning duties at a poultry farm when he heard an unusual noise coming from an egg collection conveyor. Rather than stopping the machinery before investigating, he entered a confined space between two manure conveyor belts while the equipment remained operational. His clothing became entangled in an in-running nip point between a pressure roller and the underside of the upper conveyor belt.

A colleague activated an emergency stop and emergency services attended to free the worker from the machinery. The employee was taken to hospital, where he was diagnosed with nerve damage to both arms. It took approximately three months for full function to return to his right arm. He returned to work in February 2025 and continues to be employed by the company.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had undertaken risk assessments relating to entanglement hazards and had instructed employees to wear close-fitting clothing when working near machinery.

However, inspectors found that no fixed or interlocking guards had been fitted at the drive end of the manure conveyors to prevent access to dangerous in-running nip points while the machinery was operating.

The investigation concluded that there were no physical safeguards in place to prevent a person reaching the hazardous parts of the conveyor system, nor were there measures that would automatically stop the machinery before access could be gained.

The Outcome

The company pleaded guilty to breaching Regulations 11(1) and 11(2) of the Provision and Use of Work Equipment Regulations 1998 (PUWER) and Section 33(1)(c) of the Health and Safety at Work etc. Act 1974. It was fined £53,000.

Additional Context

Under PUWER, employers are required to take effective measures to prevent access to dangerous parts of machinery. HSE states that fixed or interlocking guards are generally the most effective control measures and should be used as the primary means of protection. This case highlights the importance of applying the hierarchy of controls when managing machinery risks. While training, supervision and clothing requirements can help reduce risk, they should not be relied upon as substitutes for robust engineering controls that physically prevent access to hazardous moving parts.

Key Learning Points

- Ensure dangerous moving parts are protected by suitable fixed or interlocking guards.
- Do not rely solely on training, instructions or clothing requirements to control machinery hazards.
- Regularly review machinery safeguarding arrangements to ensure they remain effective.
- Employees should always isolate and stop machinery before investigating faults, unusual noises or blockages.
- Risk assessments should identify opportunities to eliminate or physically prevent access to hazardous areas.
- Emergency stop systems are important but should not be considered a substitute for effective guarding.



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Worker Suffered Neck and Back Fractures after Temporary Platform Collapsed

Summary

Two construction companies have been fined after a drilling operative suffered serious neck and back fractures when a temporary timber platform collapsed above him during refurbishment work in London. An investigation by the Health and Safety Executive (HSE) found significant failings in the planning, design, inspection and management of the temporary works.

What Happened

On 23 February 2024, a drilling operative was working on a refurbishment project in the City of London, where openings were being cut through five concrete floors to create a service riser shaft. Temporary wooden platforms had been installed beneath each opening to collect concrete cores and debris generated during the drilling process. While the operative was cutting an opening on the third floor, the platform above him suddenly failed, collapsing onto him along with accumulated concrete debris. He sustained fractures to his neck and back.

The Investigation

The Health and Safety Executive (HSE) investigation found that the temporary platforms had not been properly designed and no calculations had been carried out to determine the loads they could safely support. Although inspections had been recorded, they failed to identify the design deficiencies, and the individual responsible for inspecting the platforms was not a competent temporary works coordinator. Workers had been verbally instructed to clear debris regularly and avoid overloading the platforms, but no maximum safe loading had been established and there was no system to monitor compliance.

HSE also identified wider management failings, including:

- Risk assessments and method statements that were inconsistent and unclear regarding the need for protective crash decks.
- A lack of supervision of the drilling team in the period leading up to the incident.
- Poor coordination of work activities, resulting in uncertainty over where operatives should have been working.

HSE reminded duty holders that temporary structures must be properly designed, installed, inspected and maintained to withstand all foreseeable loads throughout their use.

The Outcome

The principal contractor pleaded guilty to breaching Regulation 16(2) of the Construction (Design and Management) Regulations 2015 and was fined £19,333, with £5,548 in costs.

The contractor responsible for the drilling operations pleaded guilty to breaching Regulation 15(2) of the same Regulations and was fined £13,000, with £5,548 in costs.

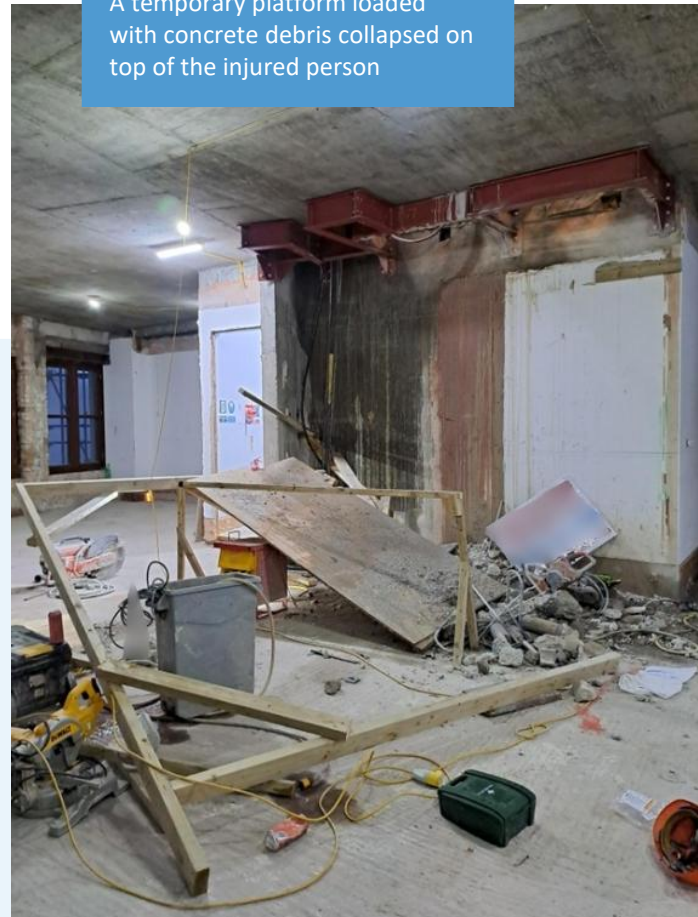
Key Learning Points

- Ensure all temporary works are properly designed and capable of supporting foreseeable loads.
- Appoint competent temporary works coordinators and inspectors.
- Establish and communicate safe loading limits for temporary structures.
- Regularly remove accumulated materials and monitor loading to prevent overloading.
- Provide clear supervision and coordination where multiple contractors are working simultaneously.
- Ensure risk assessments and method statements clearly identify responsibilities and required control measures.
- Inspect temporary works regularly and act promptly on any identified deficiencies.

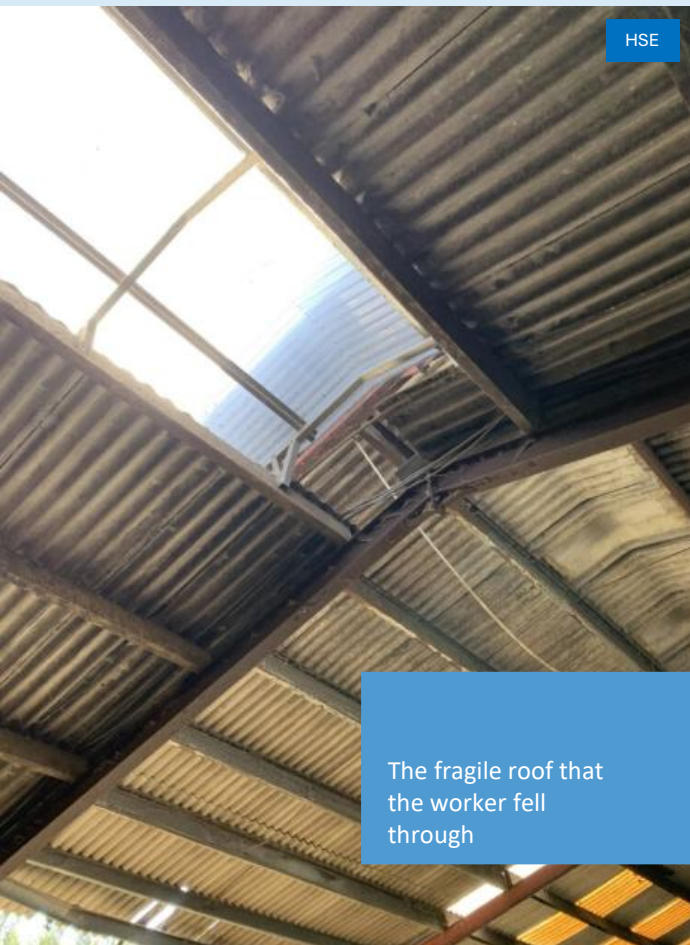
More Information

Further information about the safe management of temporary works can be accessed at:
<https://www.hse.gov.uk/construction/safetytopics/temporary-works.htm>

A temporary platform loaded with concrete debris collapsed on top of the injured person



Business Owner Received Suspended Prison Sentence After A Worker Fell Through Fragile Roof



HSE

The fragile roof that the worker fell through

Summary

A business owner has received a suspended prison sentence after an employee suffered life-changing injuries when he fell through a fragile roof while replacing skylights on a farm building. The Health and Safety Executive (HSE) investigation found that the work had been carried out without suitable measures to prevent or protect against falls from height. The employer had also failed to hold the legally required Employers' Liability Compulsory Insurance.

What Happened

On 17 June 2024, a worker was replacing roof skylights on a farm outbuilding when he was instructed to walk across a fragile roof surface. During the work, he fell through a roof light to the floor below.

The worker sustained life-changing injuries, including multiple fractures, serious shoulder injuries and damage to both lungs, requiring several operations. The injuries have left him with restricted mobility, breathing difficulties and lasting limitations affecting everyday activities.

The Investigation

The HSE investigation found that the employer had failed to implement basic fall prevention measures before instructing the worker to access the fragile roof. No suitable controls, such as crawling boards or safety netting, had been provided to prevent or minimise the consequences of a fall through the fragile roof surface. HSE also established that the employer did not have Employers' Liability Compulsory Insurance (ELCI) in place at the time of the incident, despite this being a legal requirement for most employers.

The Outcome

The employer pleaded guilty to breaching Regulation 6(3) of the Work at Height Regulations 2005 and received a 12-month prison sentence, suspended for 18 months. The court also ordered 260 hours of unpaid work and £700 in costs.

At an earlier hearing, the employer also pleaded guilty to

failing to hold Employers' Liability Compulsory Insurance in breach of the Employers' Liability (Compulsory Insurance) Act 1969.

Additional Context

Falls from height continue to be one of the leading causes of fatal and serious injuries in UK workplaces. Fragile roofs, including roof lights and skylights, present a significant risk and should never be accessed without appropriate planning, suitable equipment and effective control measures.

Employers also have a legal duty to hold Employers' Liability Compulsory Insurance so that compensation claims made by employees who are injured or become ill through work can be met.

Key Learning Points

- Never allow workers to walk directly on fragile roofs or roof lights.
- Carry out a suitable and sufficient risk assessment before any work at height begins.
- Use appropriate control measures, such as crawling boards, safety nets, or other fall prevention and protection systems.
- Ensure work at height is properly planned, supervised and carried out by competent people.
- Maintain valid Employers' Liability Compulsory Insurance where required by law.
- Regularly review work at height procedures to ensure they remain effective and compliant with legal requirements.

More Information

Further guidance is available from HSE about Working at Height at: <https://www.hse.gov.uk/work-at-height/> and about Employers' Liability (Compulsory Insurance) Act 1969 at: <https://www.hse.gov.uk/pubns/hse40.htm>



Worker Paralysed after Falling through Roof Light Opening

Summary

A construction company has been fined after a subcontracted joiner suffered life-changing injuries when he fell through an unsecured roof light opening while working on a domestic property.

What Happened

A subcontracted joiner was constructing the timber frame for a new roof when he walked across a sheet of plywood that had been placed over roof light openings. The board had not been secured and gave way beneath him, causing him to fall from height.

Only the worker's son remained on site at the time of the incident, as the rest of the workforce had already left for the day. He called an ambulance and the injured worker was taken to hospital.

The worker sustained a head injury, fractured ribs, a fractured sternum and a complete spinal cord injury. He was left paralysed from the waist down and now has no feeling below his waist, suffers severe nerve pain and requires ongoing medical care.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the principal contractor had failed to properly plan, manage and monitor the roof work. Suitable measures and equipment to prevent or protect against falls from height had not been put in place, and there was inadequate site supervision during the work.

HSE highlighted that principal contractors have a legal duty to plan, manage and monitor construction work, ensuring

subcontractors have appropriate preventive and protective measures, together with suitable supervision. HSE also emphasised the importance of using suitable work equipment and implementing effective controls to prevent falls while carrying out roof work.

The Outcome

The company pleaded guilty to breaching Regulation 13(1) of the Construction (Design and Management) Regulations 2015. It was fined £8,000 and ordered to pay £5,850 in costs together with a £2,000 victim surcharge.

Additional Context

Falls from height remain one of the leading causes of fatal and life-changing injuries within the construction industry. Temporary coverings placed over roof openings must be adequately secured and capable of supporting any foreseeable loads. Principal contractors are responsible for ensuring work is properly planned, supervised and carried out using appropriate control measures to protect everyone on site.

Key Learning Points

- Properly plan, manage and supervise all work at height.
- Ensure roof openings are securely covered or otherwise protected against falls.
- Never rely on unsecured boards or makeshift coverings to protect roof openings.
- Provide suitable work equipment and fall prevention measures before work begins.
- Ensure adequate supervision remains in place throughout the work.
- Principal contractors must verify that subcontractors are working safely and appropriate controls are maintained.

More Information

For further guidance on health and safety in roof work see: <https://www.hse.gov.uk/pubns/priced/hsg33.pdf>

Work area where the incident occurred



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Worker Suffered Leg Amputation After Road Milling Machine Incident

Summary

A road planning contractor has been fined after a worker suffered life-changing injuries when his leg became entangled in an unguarded road milling machine.

What Happened

On 14 February 2024, a 32-year-old employee was operating a road milling machine during roadworks in Basingstoke.

While using the machine, the worker's foot became caught in the rotating milling drum, pulling him into the equipment.

Emergency services were forced to amputate his right leg at the scene to free him from the machine.

The employee was unable to return to work for more than a year and continues to experience long-term physical and psychological effects, including post-traumatic stress disorder (PTSD), persistent pain and the challenges associated with living with a lifelong disability.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to take effective measures to prevent access to the dangerous rotating milling drum.

The manufacturer's protective bow, which was designed to restrict access to the milling drum, had not been fitted to the machine.

The investigation also found that it was common practice within the company to operate road milling machines without this guard in place.

The Outcome

The company pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998. It was fined £92,450 and ordered to pay £6,781 in costs.

Key Learning Points

- Never operate machinery with guards or protective devices removed.
- Ensure all machinery is used in accordance with the manufacturer's safety instructions.
- Prevent access to dangerous moving parts through suitable guarding and engineering controls.
- Challenge unsafe working practices if equipment is routinely operated without required safety features.
- Regularly inspect machinery to confirm guards remain fitted, effective and properly maintained.



HSE

More Information

HSE – Safe use of mobile work equipment:
<https://www.hse.gov.uk/work-equipment-machinery/mobile.htm>



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Worker Killed after being Struck by Mine Ventilation Fan

Summary

A mining company has been fined £150,000 after an experienced electrician was killed while carrying out electrical work at an underground quartz sand mine in the Scottish Highlands. An investigation by the Health and Safety Executive (HSE) found multiple failures relating to the modification, guarding, inspection and maintenance of a large ventilation fan.

What Happened

The incident happened on 21 October 2024 at an underground quartz sand mine. The electrician had been helping to restore power following storm damage and was working with an apprentice to disconnect a communications cable near one of the mine's ventilation fans. During the work, he became trapped in the fan and suffered fatal injuries.

The Investigation

The HSE investigation identified a number of serious safety failings. Four years before the incident, a twin fan assembly had been separated into two individual fans without a suitable risk assessment, commissioning process or documented management review.

This modification left the rotating blades of one fan much closer to the intake than permitted by recognised guarding standards. Instead of installing appropriate guarding, the company fabricated its own mesh guard, which was poorly designed and offered inadequate protection. The outlet end of the fan was left completely unguarded.

Inspectors also found that the intake guard had significantly deteriorated over time, with large sections of corroded

mesh missing. Evidence showed the damage had existed well before the incident. The fans had also been omitted from the mine's mechanical asset register, with no inspection or maintenance records available. Although electrical inspections had taken place, they failed to identify the dangerous condition of the guard.

The Outcome

The company pleaded guilty to breaching Sections 2(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. It was fined £150,000 and ordered to pay a Victim Surcharge of £11,250. Following enforcement action by HSE, the company engaged a specialist mining consultancy to bring the installation into compliance.

Key Learning Points

- Ensure all machinery modifications are subject to a suitable and sufficient risk assessment before implementation.
- Commission modified equipment formally and maintain appropriate records.
- Install guarding that complies with recognised safety standards and prevents access to dangerous moving parts.
- Regularly inspect guards and repair or replace any that become damaged or deteriorated.
- Include all mechanical equipment within asset registers and planned maintenance programmes.
- Maintain accurate inspection and maintenance records for safety-critical equipment.
- Ensure electrical inspections consider the condition of associated mechanical safety features where appropriate.
- Never rely on improvised or poorly designed guarding to protect workers from hazardous machinery.



HSE

The sister fan of the one involved in the incident – the two had originally been together as one unit



HSE

Significant areas of mesh were missing, particularly around the fan's impeller hub



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Man Electrocuted after Contacting Faulty Floodlight at Leisure Centre

Summary

A leisure facilities management company has been fined after a man was electrocuted while retrieving a football from an all-weather pitch. The Health and Safety Executive (HSE) investigation found that worn and faulty wiring on a floodlight had not been properly inspected or maintained, despite a previous electric shock incident involving the same equipment just one month earlier.

What Happened

On 17 January 2016, a 34-year-old man was playing five-a-side football at an all-weather pitch at a leisure centre in Portsmouth. After the ball went out of play, he climbed a fence to retrieve it and came into contact with a floodlight, receiving a fatal electric shock. Despite attempts by his friends to resuscitate him, he later died in hospital.

The Investigation

The HSE investigation found that the floodlight's wiring had deteriorated over several years and had not been properly inspected or maintained. HSE also established that no action had been taken to repair the defect despite an off-duty police officer receiving an electric shock from the same floodlight only a month before the fatal incident.

HSE guidance makes clear that electrical systems must be maintained so that they do not present a danger to anyone who may come into contact with them.

The Outcome

The company pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. At Portsmouth Magistrates' Court on 16 June 2026, it was fined £60,000 and ordered to pay £40,000 in costs.

Additional Context

Electrical installations exposed to the elements can deteriorate over time through weathering, corrosion and general wear. Regular inspection, testing and prompt repair of defects are essential to prevent electric shock, particularly where members of the public may be exposed to electrical equipment.

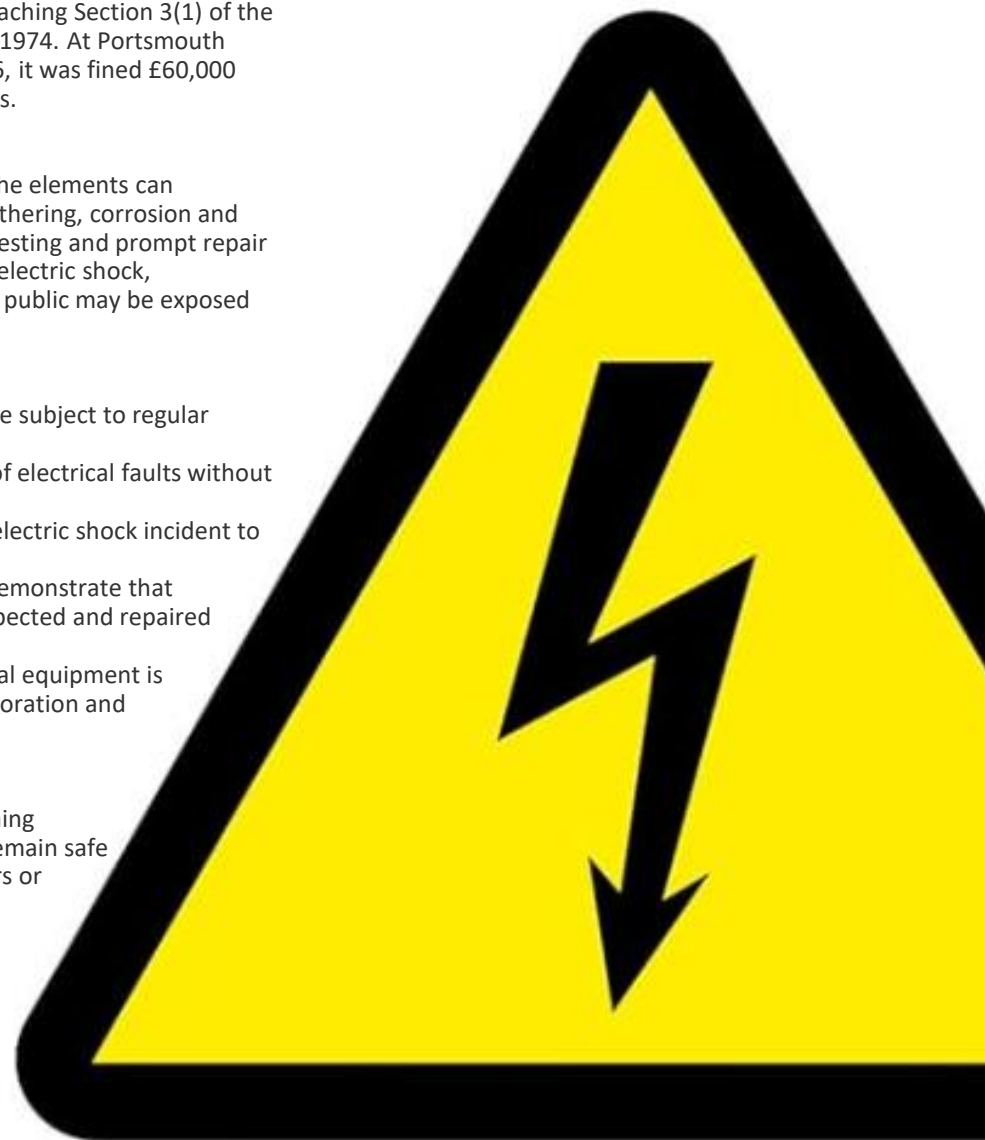
Key Learning Points

- Ensure electrical installations are subject to regular inspection and maintenance.
- Investigate and rectify reports of electrical faults without delay.
- Act immediately following any electric shock incident to prevent recurrence.
- Keep maintenance records to demonstrate that electrical systems are being inspected and repaired appropriately.
- Recognise that outdoor electrical equipment is particularly vulnerable to deterioration and requires ongoing monitoring.

More Information

HSE provides guidance on maintaining electrical systems to ensure they remain safe and do not present a risk to workers or members of the public. It can be accessed at:

<https://www.hse.gov.uk/pubns/books/hsr25.htm>



EU Proposed Changes to Emissions Trading Rules

Summary

The European Union has announced proposals to revise its climate policies by easing the pace at which businesses must reduce their greenhouse gas emissions. The planned reforms would make the EU's Emissions Trading System (ETS) more flexible, giving some industries additional time to cut emissions while continuing to support the bloc's long-term climate targets.



Background

The proposals would allow certain businesses to continue receiving emissions allowances until 2038, rather than the previously planned 2034 deadline, provided they commit to investing in decarbonisation projects. The measures must still be approved by EU member states and the European Parliament, a legislative process expected to take around a year.

EU Climate Commissioner Wopke Hoekstra said the proposals represented a more business-friendly approach while maintaining the EU's environmental ambitions. According to the European Commission, the changes are

intended to keep the ETS aligned with the EU's target of reducing greenhouse gas emissions by 90% by 2040, compared with 1990 levels.

Introduced in 2005, the ETS is the EU's primary mechanism for reducing greenhouse gas emissions. Under the scheme, power stations and industrial operators must obtain an emissions allowance for every tonne of carbon dioxide they produce, encouraging investment in cleaner technologies. Businesses can buy additional allowances or trade them, while some sectors receive free allocations to help them remain competitive against overseas companies that are not subject to equivalent carbon costs. The system also limits the total number of allowances available each year, with that cap reducing over time to drive emissions down. Under the latest proposals, the annual rate at which the cap falls would be reduced to around 3.7% from 2031 and then to 1.7% from 2036, compared with the current annual reduction rate of 4.3%.

The Commission has also proposed extending the availability of free allowances until 2038 instead of ending them in 2034, when they were originally due to be replaced by a carbon border adjustment mechanism for certain imported goods. In addition, companies with credible plans to invest in decarbonisation within Europe could receive 80% of their free allowances at the outset, with the remaining 20% released once those investments have been completed.

The proposals remain subject to approval by EU governments and lawmakers before they can take effect. If adopted, the reforms would adjust how the ETS operates while retaining its role as the European Union's principal market-based mechanism for reducing greenhouse gas emissions.

More Information

Information about the EU ETS can be seen at:
https://climate.ec.europa.eu/eu-action/carbon-markets/eu-emissions-trading-system-eu-ets_en



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Climate Extremes Are Becoming the New 'Normal' for the UK, According to the Met Office

Summary

The Met Office's latest *State of the UK Climate* report shows that 2025 was the warmest year on record in the UK, continuing a long-term trend of rising temperatures and more frequent extreme weather. Scientists say conditions that were once considered exceptional are becoming increasingly common, with hotter summers, warmer winters and more extreme temperature events now defining the UK's changing climate. The report places 2025 and the most recent decade into historical context, using more than a century of weather observations to demonstrate how the UK's climate continues to change. It also highlights changes to rainfall, sunshine, river flows, sea levels and the natural environment.

Background

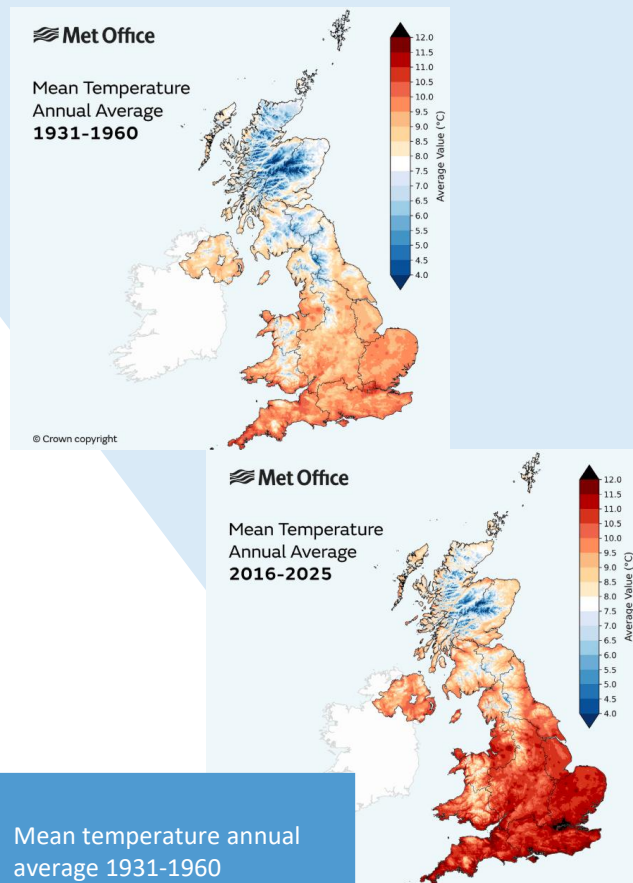
The report found that 2025 was the warmest year in the UK record, which dates back to 1884. It was also the sixth time this century that a new annual temperature record has been set, with the last four years all ranking among the five warmest on record.

According to the Met Office, the most recent decade (2016–2025) was 1.33°C warmer than the 1961–1990 average, with temperatures continuing to rise at around 0.25°C per decade since the 1980s.

The report notes that the greatest changes are being seen in temperature extremes. In parts of south-east England, the average hottest day of the year is now more than 4.5°C warmer than it was between 1961 and 1990. Days where temperatures exceed 30°C, along with very warm nights above 18°C, have more than quadrupled in Greater London during the same period.

Key Findings

- 2025 was the warmest year in the UK series from 1884, with the last four years in the top five warmest.
- 2025 included the UK's warmest spring and summer on record, with the six months (March to August) all in the top ten warmest of their respective monthly series.
- The most recent decade 2016–2025, has been 0.51°C warmer than the period 1991–2020, and 1.33°C warmer than 1961–1990.
- The average hottest day of the year has warmed by over 4.5°C in a swathe from Kent to Lincolnshire for the most recent decade, 2016–2025, compared to 1961–1990.
- The number of days over 30°C and nights over 18°C has more than quadrupled for Greater London for the most recent decade, 2016–2025, compared to 1961–1990.
- There were 297 marine heatwave days for Northwest European seas and the Northeast Atlantic in 2025, referenced to the 1991–2020 period, more than any other year since 1982 and exceeding the previous record of 178 days in 2023.
- In spring 2025, most of England and Wales received less than half of the 1991–2020 average rainfall, and in some places less than one third. England had its driest spring for over 100 years.
- The winter half-year (October to March) for the most recent decade, 2016–2025, has been 3% wetter than 1991–2020, and 13% wetter than 1961–1990, with little change for the summer half-year.
- Spring and summer 2025 combined saw less than 40% of 1991–2020 average rainfall in the driest areas, but for durations longer than six months the 1976 drought was far more severe.
- 2025 was the sunniest year in the UK series from 1910, with 1645 sunshine hours, 117% of the 1991–2020 average.
- Spring 2025 was the sunniest spring in the UK series from 1910 and also sunnier than all but three summers: 1976; 1995 and 1911.



Mean temperature annual average 1931-1960 compared to 2016-2025

Source: UK Met Office.
Crown Copyright

More Information

The *State of the UK Climate 2025* report can be accessed at: <https://rmets.onlinelibrary.wiley.com/doi/10.1002/joc.70470>



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