Keeping Workers Safe During Hot Weather

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Keeping Workers Safe During Hot Weather

Summary

Periods of hot weather can make working conditions uncomfortable and, in some circumstances, create risks to workers' health and safety. The Health and Safety Executive (HSE) advises employers to consider workplace temperature as part of their risk assessment and take appropriate action to protect workers from the effects of heat. There is no legal maximum workplace temperature in Great Britain. This is because workplaces and working conditions vary considerably, and temperature alone does not determine whether conditions are safe. However, employers still have legal duties to assess risks and put appropriate controls in place

Managing Hot Indoor Workplaces

During hot weather, employers should consider whether additional measures are needed to maintain a comfortable working environment. HSE suggests a range of practical measures, including:

- Providing fans, air cooling or air conditioning and ensuring adequate ventilation.
- Making sure windows can be opened where appropriate to increase air circulation.
- Using blinds or reflective film to reduce heating from direct sunlight.
- Moving workstations away from direct sunlight or other sources of heat.
- Insulating hot plant and pipework where these contribute to workplace temperatures.
- Providing access to cool drinking water.
- Introducing flexible working arrangements or moving workers to cooler areas where possible.
- Providing sufficient breaks to allow workers to cool down and get a drink.
- Relaxing formal dress codes where appropriate, while ensuring that any necessary personal protective equipment (PPE) continues to be worn.

Employers should also listen to their workers. If employees report that workplace temperatures are uncomfortable, HSE advises employers to reassess the risks, discuss possible measures with workers and take appropriate action.

Working Outdoors in Hot Weather

People working outside may face additional risks from heat and exposure to sunlight. HSE advises employers to consider the effect that weather conditions may have both on workers' health and on their ability to work safely. During hot weather, employers can reduce these risks by:

- Rescheduling work to cooler times of the day where possible.
- Providing more frequent rest breaks.
- Providing shaded areas for workers to rest.
- Providing free access to cool drinking water.
- Introducing shade in working areas where practicable.
- Allowing workers to remove PPE during rest periods where it is safe to do so, helping the body lose heat.
- Making sure workers can recognise the early symptoms of heat stress.

Exposure to sunlight should also be considered. excessive exposure can cause sunburn and other skin damage and, over the longer term, increase the risk of skin cancer.

Preventing Dehydration

Working in very hot conditions can cause significant fluid loss through sweating. Dehydration can affect both a person's health and their ability to work safely. HSE recommends encouraging workers to drink cool water frequently and in small amounts rather than relying on thirst as an indication that they need to drink. Thirst can already be an early indication that dehydration is developing.

Workers who are likely to be exposed to heat stress should also be encouraged to arrive at work adequately hydrated. Where work involves particularly high levels of heat or physical exertion, employers may need to consider more specific arrangements for maintaining hydration.

Recognising Heat Stress

Heat stress occurs when the body's normal methods of controlling its internal temperature begin to fail. The risk is not determined by air temperature alone. Work rate, humidity, air movement, clothing and PPE can all affect how the body responds to heat.

HSE identifies symptoms of heat stress that can include:

- Difficulty concentrating.
- Muscle cramps.
- Heat rash.
- Severe thirst.
- Fainting.
- Heat exhaustion, which can include fatigue, dizziness, nausea, headache and moist skin.
- Heat stroke, which can include hot, dry skin, confusion, convulsions and loss of consciousness.

> Heat stroke can be fatal if it is not identified and addressed quickly.

Where there is a risk of heat stress, employers should consider the physical demands of the work, the working environment, clothing and PPE, and factors that may make individual workers more susceptible. Controls can include reducing the work rate, using mechanical aids, limiting the amount of time workers spend in hot conditions and providing regular breaks in cooler areas.

More Information

More information can be found on the HSE website at:
https://www.hse.gov.uk/temperature/employer/
https://www.hse.gov.uk/temperature/employer/managing.htm

Worker Sustained Serious Leg Injuries after Foot Became Trapped in Unguarded Conveyor

Summary

A waste management company has been fined after an employee suffered serious leg injuries when his foot became trapped in an unguarded conveyor while loading bins. The Health and Safety Executive (HSE) found that inadequate guarding and an insufficient risk assessment exposed workers to a foreseeable risk of serious injury.

What Happened

The incident took place on 21 November 2024 at a clinical waste management site in Oldham. While loading a bin conveyor, the worker's foot slipped into an unguarded conveyor channel, resulting in several serious fractures to his right leg.

The Investigation

HSE's investigation found that the company had failed to carry out a suitable and sufficient risk assessment for the task. It also failed to provide appropriate guarding to prevent workers from accessing dangerous parts of the conveyor machinery. HSE guidance states that employers must prevent access to dangerous parts of machinery or ensure hazardous movement stops before anyone can enter a danger zone. This is typically achieved through fixed guards, although interlocked guards, pressure-sensitive mats or other protective measures may be appropriate where routine access is required.

The Outcome

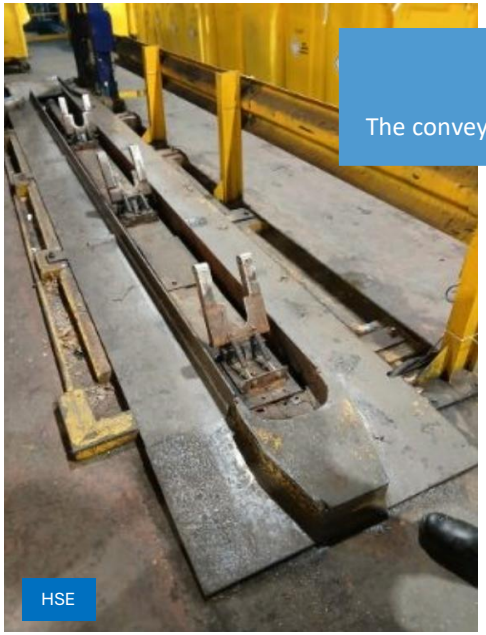
The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £300,150, ordered to pay a £2,000 victim surcharge, and £3,931.85 in costs.

Key Learning Points

- Carry out suitable and sufficient risk assessments for all machinery-related tasks.
- Ensure dangerous moving parts are effectively guarded to prevent access.
- Use fixed guards wherever possible, with interlocked guards or other engineered safeguards where routine access is necessary.
- Regularly inspect and maintain machine guards to ensure they remain effective.
- Provide workers with appropriate training on machinery hazards and safe systems of work.
- Never allow machinery to operate where workers could access dangerous moving parts without adequate protection.

More Information

Further guidance on machinery safety and guarding is available at: https://www.hse.gov.uk/pubns/priced/l22.pdf



The conveyor channel

Worker Died Following Fall Through Window Opening

Summary

A construction company has been fined £50,000 after a worker suffered fatal injuries when he fell more than 3m through an unprotected window opening. An investigation by the Health and Safety Executive (HSE) found that the company had recognised the risk presented by a number of unglazed window openings but had not put suitable measures in place to prevent workers falling through them.

What happened

The worker was employed as a labourer on a project to redevelop a former department store into commercial and residential units. As part of the work, window openings had been created in an external wall for the installation of glazed Juliet doors. However, some of the doors could not be installed because they had been delivered with damaged glazing panels. This left four window openings unglazed.

On 27 July 2022, the worker was on an external scaffolding platform when he fell through one of the unglazed openings, landing on the internal concrete ground floor more than 3m below. He was taken to hospital but died from his injuries several days later.

The investigation

The HSE investigation found that the company had recognised that the unglazed window openings presented a risk of workers falling from the scaffolding platform into the building. However, protective boarding was not installed over the openings until the hours following the incident. HSE identified that it would have been reasonably practicable to install boarding over the openings, or additional internal scaffolding guard rails, as soon as the window openings had been created. The investigation also found that the legally required weekly scaffolding inspections had not been carried out for several weeks before the incident.

As a result, an opportunity was lost for a competent scaffolding inspector to identify the risks presented by the unprotected window openings.

The outcome

The company pleaded guilty to breaching Regulation 13(1) of the Construction (Design and Management) Regulations 2015. It was fined £50,000 and ordered to pay £11,347 in costs.

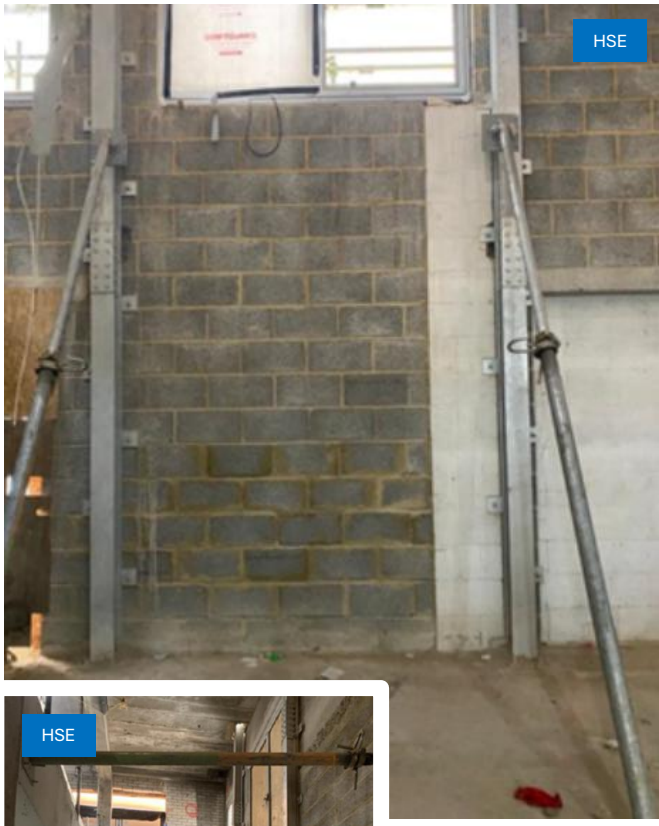
Key Learning Points

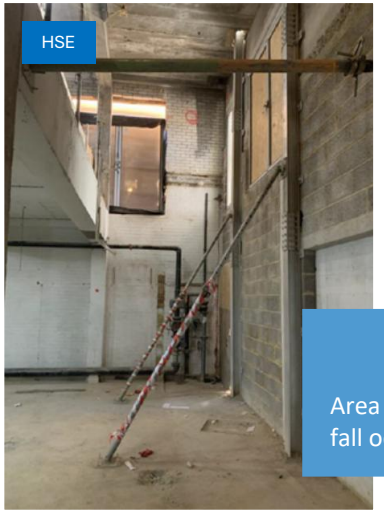
- Changes to planned work can introduce new risks and should trigger an immediate review of existing control measures.
- Openings that create a risk of falling must be properly protected as soon as they are created.
- Temporary measures, such as secure boarding or additional guard rails, can be necessary when permanent installations are delayed or cannot proceed as planned.
- Scaffolding must be inspected at the legally required intervals by a competent person.
- Routine inspections provide an important opportunity to identify hazards that may have arisen as work progresses.
- Recognising a hazard is not enough. Appropriate control measures must be implemented promptly to prevent exposure to the risk.

More information

Further guidance on managing the risks associated with work at height is available from HSE website at: https://www.hse.gov.uk/pubns/indg401.htm

Police bodycam footage of the openings





Area where the fall occurred

Worker Fell Through Unprotected Loft Hatch

Summary

A roofing company has been fined after a worker suffered serious, life-changing injuries when he fell through an unprotected loft hatch while carrying out re-roofing work at a domestic property.

What Happened

On 13 May 2024, a roofer was working on a domestic property as part of a re-roofing project. During the work, he was removing internal insulation within the roof space when he stepped onto an unguarded loft hatch that had not been identified or protected.

The worker fell approximately 11 feet to the floor below, landing on his back. He sustained fractures to his L1 vertebra and hip. As a result of his injuries, he has been unable to return to work, and his employment was subsequently terminated.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to adequately plan the work at height.

HSE identified that suitable measures had not been put in place to prevent falls and that competent supervision of the work was not being provided. The investigation also found that those responsible for overseeing the work lacked the necessary training and experience to safely manage construction-related activities.

The Outcome

The company pleaded guilty to breaching Regulation 4(1) of the Work at Height Regulations 2005.

It was fined £20,000 and ordered to pay £5,607 in costs.

Additional Context

Falls from height remain one of the leading causes of fatal and major injuries within the construction industry. Effective planning, risk assessment, supervision and the implementation of suitable control measures are essential to prevent workers from falling through openings, fragile surfaces and other hazards associated with roof work.

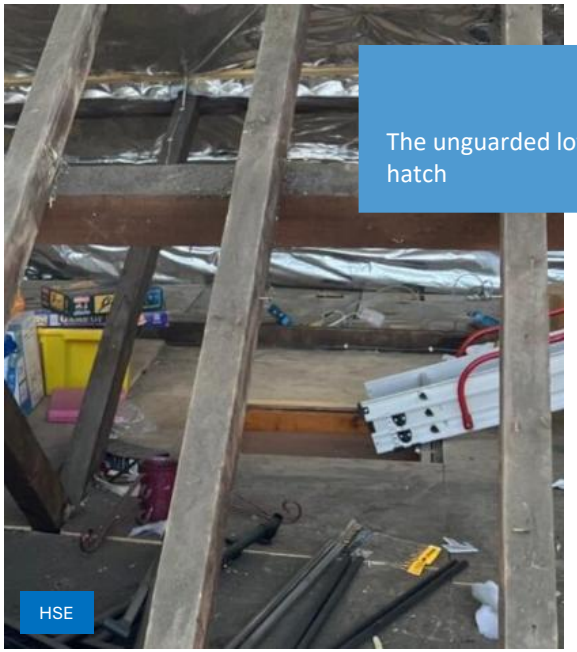
HSE guidance on roof work highlights the importance of identifying potential fall hazards, providing appropriate protection measures, ensuring workers are competent, and maintaining adequate supervision throughout the task.

Key Learning Points

- Plan all work at height thoroughly before work begins.
- Identify and protect loft hatches, openings and other fall hazards.
- Ensure suitable measures are in place to prevent falls.
- Provide competent supervision for construction and roofing activities.
- Verify that those managing work have the necessary training, knowledge and experience.
- Regularly review risk assessments to ensure they remain suitable for the work being undertaken.

More Information

Work at height:
https://www.hse.gov.uk/work-at-height/index.htm
Roof work:
https://www.hse.gov.uk/construction/safetytopics/roofwork.htm



The unguarded loft hatch

Latest Annual Work-related Fatalities Published

Summary

Great Britain remains one of the safest places in the world to work, according to new analysis published by the Health and Safety Executive (HSE). The analysis was released alongside HSE's annual work-related fatality statistics, which show that 126 workers were killed in work-related incidents during 2025/26. Excluding the years affected by the coronavirus pandemic, this is provisionally the lowest annual number of worker fatalities recorded in Great Britain.

Workplace Fatalities Continued to Fall

The latest figures continue a long-term downward trend in fatal workplace injuries.

> There were 126 worker deaths in 2025/26, compared with 217 in 2005/06 and 495 in 1981.

For the first time, HSE has also developed analysis comparing Great Britain's rate and trend of fatal worker injuries with those of 35 other countries around the world. HSE says the findings provide further evidence that Great Britain continues to be one of the safest places in which to work.

Industries With the Highest Fatality Rates

Construction recorded the highest number of worker deaths during 2025/26, followed closely by agriculture, forestry and fishing:

- Construction: 25 deaths
- Agriculture, forestry and fishing: 22 deaths

However, when the size of the workforce is taken into account, agriculture, forestry and fishing had the highest fatal injury rate, at 8.09 deaths per 100,000 workers.

Waste and recycling had the second-highest rate, at 5.47 deaths per 100,000 workers. This compares with an average fatal injury rate of 0.37 per 100,000 workers across all industries.

Falls From Height Remained the Leading Cause

Falls from height continued to be the most common cause of fatal workplace injuries.

> There were 31 deaths resulting from falls from height during 2025/26, accounting for around a quarter of all worker fatalities.

Older workers were also disproportionately represented in the figures. Workers aged 60 and over accounted for 40 fatalities – around one-third of all worker deaths – despite representing only 12% of the workforce.

Members of the Public

Work-related incidents also resulted in the deaths of 104 people who were not at work at the time. These figures relate to members of the public who were killed because of work-related incidents despite not themselves being engaged in work.

Mesothelioma Deaths Fell

HSE has separately published its latest annual figures for mesothelioma, a cancer associated with previous exposure to asbestos.

There were 2,146 mesothelioma deaths in Great Britain in 2024, 109 fewer than in 2023. This was also substantially below the annual average of 2,508 deaths recorded between 2011 and 2020.

Many current mesothelioma deaths result from asbestos exposures that occurred before the 1980s because of the long period that can pass between exposure and development of the disease. HSE expects annual mesothelioma deaths to continue to decline.

Additional Context

The annual workplace fatality figures relate to deaths resulting from work-related accidents. They do not include deaths caused by occupational diseases or diseases resulting from particular occupational exposures. Although the long-term reduction in fatal workplace injuries is significant, the latest figures show that 126 workers still lost their lives in work-related incidents in a single year, with falls from height and risks within construction and agriculture continuing to feature prominently.

More Information

The fatal statistics can be accessed at: https://www.hse.gov.uk/statistics/fatals-overview.htm
The international comparison can be accessed at: http://www.hse.gov.uk/statistics/assets/docs/international-comparisons.pdf

HSE Stopped Engineered Stone Work at Four Companies Over Silica Dust Risks

Summary

Four companies have been ordered to stop working with engineered stone after Health and Safety Executive (HSE) inspectors identified inadequate measures to protect workers from exposure to dangerous silica dust. The enforcement action forms part of a nationwide HSE inspection campaign targeting businesses that manufacture, fabricate or work with engineered stone. HSE has warned that businesses failing to control exposure to respirable crystalline silica (RCS) can expect enforcement action, with more than 1,000 inspection visits planned.

The Enforcement Action

A prohibition notice requires dangerous work to stop immediately and prevents it from restarting until the risks that led to the notice have been adequately addressed. Inspectors also identified other shortcomings, including failures relating to health surveillance, suitable respiratory protective equipment (RPE), local exhaust ventilation and machinery guarding.

Why HSE Is Taking Action

Engineered stone can contain high levels of crystalline silica. Cutting and processing the material can release very fine silica dust into the air, which can be inhaled deep into the lungs. Exposure to RCS can cause silicosis, a serious and incurable lung disease. HSE's action follows concerns about cases of silicosis affecting young workers who have worked with engineered stone.

HSE research found that dry fabrication can result in exposure to RCS at levels five to ten times higher than when wet processing methods are used.

The regulator has consequently made clear that dry cutting of engineered stone is unacceptable. HSE has also highlighted the availability of engineered stone products with lower silica content, which can reduce the risk at source.

What HSE Expects Employers to Do

HSE has published specific COSHH guidance for businesses working with engineered stone, setting out the measures employers should take to control exposure to silica dust. These include:

- switching to engineered stone with a lower silica content;
- using on-tool water suppression;
- controlling mist generated during wet processing;
- providing appropriate respiratory protective equipment (RPE); and
- carrying out regular health surveillance.

These measures should form part of an effective system for controlling workers' exposure to RCS.

Wider Inspection Campaign

The enforcement action forms part of a wider package of measures introduced by HSE to improve standards across the engineered stone industry. A nationwide inspection campaign is running throughout 2026, with HSE planning to undertake more than **1,000 visits**. HSE's campaign is intended to ensure appropriate controls become standard practice throughout the industry and that employers, managers, supervisors and workers understand what is required when engineered stone is processed.

More Information

HSE has published specific guidance for fabricators, installers and distributors of engineered stone, including information for managers and supervisors. It can be accessed at: https://www.hse.gov.uk/stonemasonry/working-engineered-stone-control-silica-risk.htm

Unsecured Snow Machine Led to Child Being Injured by Falling Glass

Summary

A ceramics manufacturer has been fined after a 12-year-old girl was injured by broken glass when an unsecured artificial snow machine fell from a window during a Christmas lights switch-on event. The girl suffered a deep cut to her head that required hospital treatment.

What Happened

On 23 November 2024, the girl attended an annual Christmas lights switch-on event with her family at a gift shop in Hanley, Stoke-on-Trent.

An artificial snow machine had been positioned in a window opening above the shop. During the event, the machine fell from the building towards the area below.

As it fell, the machine struck a light, causing a shard of broken glass to hit the girl on the head. She sustained a deep cut and required treatment in hospital.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to properly assess the risks associated with using the snow machine.

The machine had also not been adequately secured to prevent it from falling from the window, despite the manufacturer's instructions clearly explaining how it should be safely installed.

The Work at Height Regulations 2005 require employers to take suitable steps to prevent materials or objects from falling where they could cause injury to employees or members of the public.

The Outcome

The company pleaded guilty to breaching Regulation 10(1) of the Work at Height Regulations 2005 and Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £266,666 and ordered to pay £4,931 in costs and a £2,000 victim surcharge.

Key Learning Points

- Equipment positioned at height must be properly secured where there is a risk of it falling and causing injury.
- Risk assessments should consider the danger posed to members of the public as well as employees.
- Manufacturers' installation and safety instructions should be followed when equipment is being positioned and used.
- Employers must take suitable steps to prevent materials and objects falling where they could cause injury.
- Temporary installations used for events should be subject to appropriate planning and risk controls.


HSE

The snow machine and gift shop

Worker Sustained Serious Leg Injuries after Foot Became Trapped in Unguarded Conveyor

Summary

A waste management company has been fined after an 18-year-old employee suffered serious leg injuries when his foot became trapped in an unguarded conveyor while loading bins. The Health and Safety Executive (HSE) found that inadequate guarding and an insufficient risk assessment exposed workers to a foreseeable risk of serious injury.

What Happened

The incident took place on 21 November 2024 at a clinical waste management site in Oldham. While loading a bin conveyor, the worker's foot slipped into an unguarded conveyor channel, resulting in several serious fractures to his right leg.

The Investigation

HSE's investigation found that the company had failed to carry out a suitable and sufficient risk assessment for the task. It also failed to provide appropriate guarding to prevent workers from accessing dangerous parts of the conveyor machinery.

HSE guidance states that employers must prevent access to dangerous parts of machinery or ensure hazardous movement stops before anyone can enter a danger zone. This is typically achieved through fixed guards, although interlocked guards, pressure-sensitive mats or other protective measures may be appropriate where routine access is required.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £300,150, ordered to pay a £2,000 victim surcharge, and £3,931.85 in costs.

Additional Context

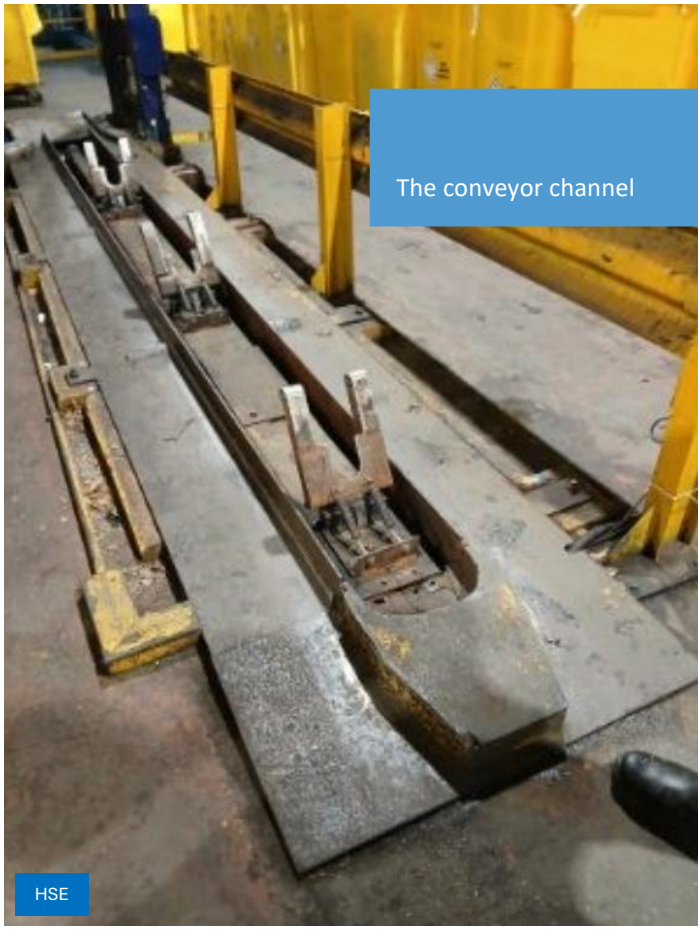
Machinery remains one of the leading causes of serious workplace injuries. Effective risk assessments, suitable machine guarding and regular inspections are essential to protect workers from moving parts and entrapment hazards. Employers should also ensure employees receive appropriate training and that any machinery safeguards are never removed or bypassed.

Key Learning Points

- Carry out suitable and sufficient risk assessments for all machinery-related tasks.
- Ensure dangerous moving parts are effectively guarded to prevent access.
- Use fixed guards wherever possible, with interlocked guards or other engineered safeguards where routine access is necessary.
- Regularly inspect and maintain machine guards to ensure they remain effective.
- Provide workers with appropriate training on machinery hazards and safe systems of work.
- Never allow machinery to operate where workers could access dangerous moving parts without adequate protection.

More Information

Further guidance on machinery safety and guarding is available at: https://www.hse.gov.uk/pubns/priced/l22.pdf



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The unguarded conveyor

Worker Suffered Life-Changing Injuries after being Drawn into Conveyor Machinery

Summary

A waste and recycling company has been fined after a worker suffered life-changing injuries when their arm was dragged into an unguarded conveyor belt while attempting to clear a blockage. The incident highlights the importance of effective machine guarding and safe isolation procedures before carrying out maintenance or cleaning tasks.

What Happened

On 27 January 2024, a worker at a waste and recycling facility in Bristol was attempting to clear a blockage on a conveyor system when they slipped and came into contact with the unguarded tail-end of the conveyor belt. Their arm was pulled into the machinery, causing crush injuries, multiple bone fractures, severe lacerations, nerve damage and a fractured rib.

In a victim personal statement, the worker explained that the injuries have prevented them from enjoying activities they once loved, including cycling, playing darts and snooker with their sons, and working on cars. They described the incident as the most traumatic experience of their life, with lasting physical and mental effects.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to prevent access to dangerous parts of the conveyor machinery. It had also failed to implement a safe system of work for clearing blockages, including appropriate isolation procedures before maintenance activities were undertaken.

HSE reminded employers that the Provision and Use of Work Equipment Regulations 1998 (PUWER) require dangerous parts of machinery to be adequately guarded. Employers must also ensure suitable risk assessments are completed and that safe systems of work, clear instructions, training and effective supervision are in place whenever employees are required to carry out maintenance or cleaning tasks.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998.

It was fined **£64,666** and ordered to pay **£4,657** in costs.

Key Learning Points

- Ensure dangerous parts of machinery are effectively guarded to prevent access.
- Never clear blockages or carry out maintenance on machinery unless it has been safely isolated and locked off.
- Carry out suitable and sufficient risk assessments for maintenance and cleaning activities.
- Provide clear safe systems of work, supported by training and supervision.
- Regularly inspect guarding arrangements to ensure they remain effective and are not removed or bypassed.

More Information

Further guidance on machinery safety and the Provision and Use of Work Equipment Regulations 1998 (PUWER) is available from HSE at:
https://www.hse.gov.uk/pubns/books/puwer.htm

Worker Suffered Leg Amputation in Chemical Burn Incidents

Summary

A chemical manufacturing company has been fined £3.8 million after two employees suffered serious chemical burns in separate incidents involving caustic soda. One worker required a below-knee amputation, while another sustained burns that required skin grafts.

What Happened

The first incident occurred in December 2019 when a chemical loader was walking around the site and stepped into a puddle suspected to contain caustic soda. The worker's safety boots did not provide adequate protection against the hazardous substance, resulting in severe burns to his foot and lower leg. His injuries were so serious that his leg had to be amputated below the knee. He has been unable to return to work since.

The second incident took place in August 2022 at another site operated by the same company. A worker was manually decanting a 50% concentration caustic soda solution into containers used to top up larger storage units. During the task, drips from a hose fell onto his foot, causing burns that later required skin grafts. He subsequently returned to work.

The Investigation

An investigation by the Health and Safety Executive (HSE) identified significant failings at both sites relating to the management of hazardous substances.

In the first incident, investigators found multiple leaks of hazardous substances from pipework, valves, hoses and vessels. There was no suitable system for inspecting, maintaining or testing equipment to prevent leaks. The company had also failed to adequately manage spillages, the ground conditions allowed contaminated liquid to collect in puddles, and there were insufficient designated walkways to keep workers away from hazardous areas.

In the second incident, HSE found there was no risk assessment or documented safe system of work for the manual handling and decanting of caustic soda. Investigators also identified that an existing automated dosing system could have been used, eliminating the need for workers to manually handle the hazardous chemical.

The Outcome

The company pleaded guilty to two breaches of Regulation 7(1) of the Control of Substances Hazardous to Health Regulations 2002. The organisation was fined £3.8 million and ordered to pay costs of £124,748.

Key Learning Points

- Ensure robust inspection, maintenance and testing programmes are in place for equipment containing hazardous substances.
- Promptly identify, report and rectify leaks from pipework, hoses, valves and vessels.
- Carry out suitable and sufficient risk assessments for all activities involving hazardous substances.
- Apply the hierarchy of control by eliminating hazardous tasks wherever reasonably practicable.
- Provide clearly defined pedestrian routes and maintain site surfaces to prevent hazardous substances collecting in walkways.
- Ensure spill management arrangements are effective and understood by workers.
- Verify that personal protective equipment is suitable, properly maintained and appropriate for the substances being handled.
- Avoid relying solely on PPE where engineering or process controls can eliminate or significantly reduce risk.

More Information

See: https://www.hse.gov.uk/pubns/priced/l5.pdf

The caustic loading area at the site

Unprotected Opening Led to Worker Suffering Life-Changing Injuries

Summary
A construction company has been fined after a worker suffered life-changing injuries when he fell approximately 2.6m through an unprotected opening while replacing steps at a residential property.

What Happened
On 16 July 2024, a 65-year-old bricklayer was helping to replace steps at a residential property in Leamington Spa. The previous day, railings had been removed to allow the old steps to be taken out, leaving a gap in the balustrade. While helping to install the new steps, the worker fell through the opening into a basement lightwell approximately 2.6m below. He sustained serious injuries, including head trauma and a stroke. The injuries have had lasting effects, including difficulties with writing and holding objects, impaired speech and memory, and mobility problems that sometimes require him to use a wheelchair.

The incident was described as 'entirely preventable'


HSE


HSE

The Investigation
An investigation by the Health and Safety Executive (HSE) found that the company had failed to put suitable and sufficient measures in place to prevent a fall from height. No task-specific risk assessment or method statement had been produced for the work. The company had also failed to ensure that scaffolding or other suitable protective measures were in place before employees began replacing the steps.

HSE states that work at height must be properly planned and suitable and sufficient measures taken to prevent falls. This includes assessing the risks and providing appropriate physical safeguards, such as scaffolding, guardrails or suitable coverings.

Key Learning Points
- Work at height must be properly planned before it begins.
- Task-specific risks should be assessed and appropriate control measures identified.
- Open edges and gaps that create a fall risk must be suitably protected.
- Physical fall-prevention measures should be in place before workers are exposed to the risk.
- Removing existing railings or barriers can introduce significant new risks that must be controlled.

The Outcome
The company pleaded guilty to breaching Regulation 6(3) of the Work at Height Regulations 2005. It was fined £16,000 and ordered to pay £7,638 in costs. The HSE inspector described the incident as entirely preventable and emphasised the importance of properly planning and risk assessing work at height and ensuring appropriate control measures are in place.

More Information
Further information on managing the risks associated with work at height is available from HSE at:
https://www.hse.gov.uk/work-at-height/

Company Fined After A Maintenance Worker Was Fatally Injured Repairing Industrial Door

Summary

A printing company has been fined £400,000 after a maintenance worker suffered fatal injuries while attempting to repair an industrial overhead door. A Health and Safety Executive (HSE) investigation found the company had failed to properly maintain the doors, allowed an untrained employee to carry out high-risk repairs, and had not implemented safe systems of work despite previous incidents involving the same equipment.

What Happened

On 5 September 2022, a 59-year-old maintenance worker was repairing an electrically operated sectional overhead door at the company's manufacturing facility in Cardiff. While attempting to re-tension the door springs using an industrial wrench, the tool slipped. The spring unwound violently, causing the wrench to be ejected and strike the worker. He sustained catastrophic injuries and died the following day.

The Investigation

The HSE investigation found that the company had failed to adequately maintain its electrically operated sectional overhead doors, despite two previous incidents in which employees had been injured by failing doors.

Inspectors found there was no programme of routine inspection or preventative maintenance, allowing the condition of the doors to deteriorate.

The investigation also established that the maintenance worker had repeatedly been permitted to repair the doors despite lacking the necessary training. HSE found the company had failed to carry out a suitable risk assessment, establish a safe system of work, or provide appropriate tools and equipment for the task.

HSE guidance states that powered sectional overhead doors are classed as work equipment under the Provision and Use of Work Equipment Regulations 1998 (PUWER). Employers must ensure such equipment is suitable for use, properly maintained and regularly inspected by a competent person.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and Regulation 5(1) of the Provision and Use of Work Equipment Regulations 1998.

It was fined £400,000 and ordered to pay £17,854 in costs at Merthyr Tydfil Magistrates' Court on 17 June 2026.

Key Learning Points

- Ensure powered doors are subject to regular inspection and preventative maintenance.
- Only competent and appropriately trained personnel should carry out repairs involving tensioned springs or other hazardous components.
- Carry out suitable and sufficient risk assessments before maintenance work begins.
- Develop and implement safe systems of work for maintenance activities.
- Provide workers with the correct tools and equipment for the task.
- Investigate previous equipment failures and take prompt corrective action to prevent recurrence.
- Ensure all work equipment complies with the requirements of PUWER and remains safe throughout its service life.

More Information

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

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Unstable Wall Panels Collapsed, Causing Fatal Fall from Scissor Lift

Summary

A company has been fined after a worker suffered fatal injuries when wall panels collapsed during the dismantling of a cleanroom structure, throwing him from a scissor lift. The Health and Safety Executive (HSE) investigation found that the risks associated with dismantling a structure installed by another party had not been adequately assessed or controlled. The company had also failed to ensure that its risk assessment and method statement were communicated to those carrying out the work.

What Happened

The 32-year-old labourer was involved in dismantling a cleanroom at a specialist technology centre in Renfrew in November 2022.

He was working from a scissor lift at a height of approximately four metres, removing wall panels from the structure. The cleanroom consisted of a steel frame with walls and a roof formed from polyurethane panels measuring around 6.1 metres high.

After the roof had been removed, the remaining wall panels did not have sufficient lateral support to maintain their stability. A series of panels collapsed and struck the platform of the scissor lift, throwing the worker onto the concrete warehouse floor below. He suffered multiple serious injuries, including a traumatic brain injury, fractures and lung injuries. He died in hospital the following day.

The Investigation

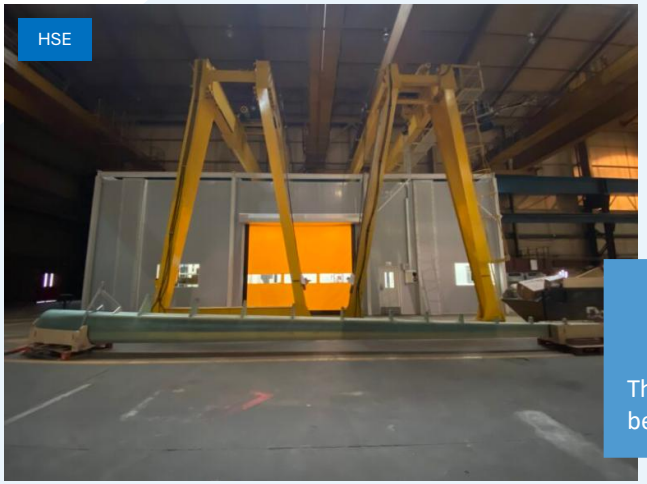
The HSE investigation found that the company had failed to adequately assess and manage the risks involved in dismantling a structure that it had not originally installed. The company's risk assessment and method statement did not sufficiently address the possibility of an unplanned collapse caused by structural instability. Its own method statement stated that A-frame props or other supports should be installed where necessary, but no such supports were being used when the incident occurred.

Before starting work, the company had visually inspected the exterior of the cleanroom and assumed that it had been constructed to industry standards. However, HSE found that relying on this assumption was unsafe. Dismantling a structure constructed by another party could involve hidden defects or other unknown factors capable of affecting its structural stability.

HSE also found that the risk assessment and method statement had not been communicated to the employees undertaking the work. As a result, those carrying out the dismantling operation had not been adequately informed about the risks involved.

The Outcome

The company pleaded guilty to offences under the Health and Safety at Work etc. Act 1974. It was fined £50,000 and ordered to pay a victim surcharge of £3,750.



The cleanroom before being dismantled

Key Learning Points

- Dismantling work should be properly planned and the potential for structural instability assessed before work begins.
- Structures should not be assumed to have been constructed as expected, particularly where they were installed by another contractor or where their construction cannot be fully verified.
- Removing roofs, panels, bracing or other structural elements can significantly affect the stability of the remaining structure.
- Temporary supports, props or other control measures identified as necessary within a safe system of work must actually be provided and used.
- Risk assessments and method statements should address the sequence of dismantling and the possibility of foreseeable unplanned collapse.
- Safe systems of work must be effectively communicated to the workers expected to follow them.
- Work at height arrangements should consider not only the risk of falling from equipment, but also foreseeable events that could cause a worker to be thrown or displaced from it.

Additional Context

Falls from height continue to be a major cause of fatal workplace accidents in Great Britain.

HSE's figures for 2025/26 recorded 31 worker deaths resulting from falls from height, accounting for approximately a quarter of all work-related worker fatalities during the year

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England Delays Mandatory Flexible Plastic Collections Until 2030

Summary

The UK government is planning to delay mandatory kerbside collections of flexible plastic packaging in England from 2027 until 2030.

The change has prompted concerns from parts of the packaging and recycling industry that the additional three-year wait could create uncertainty, discourage investment in recycling infrastructure and widen differences in recycling arrangements across the UK.

The government intends to legislate for the revised timetable in autumn 2026.

Background

Flexible plastic packaging includes items such as plastic bags, wrappers, pouches and films. Although widely used, these materials can be more difficult to collect, sort and recycle than rigid plastics such as bottles and containers. Mandatory collections of flexible plastics from households in England had been expected to begin in 2027. Businesses across the packaging and recycling supply chain have consequently been preparing for the change, including investing in packaging redesign, sorting and reprocessing capacity, and supplies of recycled material.

The Industry Council for Packaging and the Environment (INCPEN) has expressed disappointment at the postponement and warned that it creates commercial uncertainty for organisations that had planned investments around the original deadline.

It has called for producers, local authorities, waste management businesses and reprocessors to work together to develop the collection systems, infrastructure and markets needed to make flexible plastic recycling successful across England.

The Local Authority Recycling Advisory Committee (LARAC), however, has welcomed the delay as a pragmatic response to the practical difficulties associated with developing sufficient collection and recycling infrastructure.

Industry representatives have also highlighted a shortage of sorting and reprocessing capacity and viable end markets for recycled flexible plastics. While the additional time could help address these issues, there are concerns that delaying mandatory collections could itself weaken the incentive to invest in the necessary infrastructure.

The change could also result in different approaches across the UK. Wales and Scotland currently remain committed to introducing mandatory flexible plastic collections from 2027.

Another issue is the future of front-of-store collection schemes operated by retailers. These schemes allow consumers to return flexible plastics to participating shops and supermarkets but were not intended to provide a permanent alternative to widespread household collections. The debate highlights the importance of policy certainty in encouraging investment in recycling infrastructure and creating viable markets for materials that have traditionally been difficult to recycle.

More Information

The INCPEN website can be accessed at:
https://incpen.org/
The LARAC website can be accessed at:
https://larac.org.uk/

Flexible plastic packaging can be difficult to collect, sort and recycle

Urban Canals Could Help Cities Stay Cooler During Heatwaves

Summary

Urban canals could play an important role in helping towns and cities cope with increasingly intense heatwaves, according to new research from The University of Manchester.

The study found that canals can reduce daytime temperatures in their immediate surroundings, with the cooling effect exceeding 2°C in some locations during heatwaves. Researchers say this existing network of waterways could therefore form a valuable part of climate adaptation strategies alongside parks, trees and other green infrastructure.

Background

Researchers assessed the cooling effects of urban canals across Great Britain and Ireland, modelling the thermal behaviour of more than 2,300 sections of canal over an entire year.

The research found that canals typically reduced daytime temperatures within around 20 to 50 metres of the water by an average of approximately 0.8°C.

During heatwaves, the effect became considerably stronger, with temperature reductions ranging from around 1.5°C to 2.3°C. Cooling was particularly noticeable during spring and early summer, when reductions of around 1.2°C to 1.4°C were recorded.

The researchers also examined the potential effect on heat stress. When canal cooling was taken into account, the number of hours classified as presenting a moderate heat risk fell by around 58%, while hours associated with high heat risk reduced by approximately 74%.
This could be particularly significant because around 6.2 million people live within one kilometre of Britain's urban canal network.

The researchers noted that canals can have some disadvantages during hot weather. Water retains heat for longer than surrounding surfaces, meaning canals can produce a small warming effect overnight. Increased humidity close to waterways can also reduce some of the benefits to thermal comfort.

Despite this, the researchers believe urban canals should be considered as part of climate-responsive urban design. As well as providing cooling, accessible waterways can offer wider health and wellbeing benefits and provide attractive routes for walking and cycling.

The findings highlight how infrastructure originally developed for Britain's industrial past could have a new role in helping urban areas adapt to a warmer climate.

More Information

The research was led by The University of Manchester and published in *Nature Communications*. (Source: ISEP)

Meta Face Landmark US Trial Over Alleged Harm to Young Social Media Users

Summary

Meta is facing a landmark US court case over allegations that Facebook and Instagram were deliberately designed in ways that encouraged children and teenagers to spend more time on the platforms, while exposing them to potential harm.

Attorneys general from 29 US states are pursuing claims against the technology company, including allegations relating to the collection and use of children's data and the design of features intended to increase engagement.

The case could have major implications for how social media platforms are designed for younger users, with the states seeking both substantial financial damages and significant changes to features including infinite scrolling, notifications and recommendation algorithms.

Background

The legal action forms part of a much wider challenge to social media companies over their treatment of children and young people.

The states allege that Meta designed Facebook and Instagram to keep young people using its platforms and misled consumers about their safety. They also claim that children's personal information was collected and used in breach of federal privacy law.

Meta denies the allegations and maintains that it has developed protections intended to support the safety of teenagers using its services.

In June 2026, US District Judge Yvonne Gonzalez Rogers rejected Meta's attempt to dismiss significant parts of the case. The judge also found that Meta had failed to comply with certain notice and parental consent requirements under the US Children's Online Privacy Protection Act.

The trial, which is expected to last several weeks, is being overseen by Judge Gonzalez Rogers in California. An advisory jury will consider evidence and provide its findings, although the ultimate decision will be made by the judge.

Changes Being Sought

The states are not simply seeking financial compensation. They are also seeking changes that could fundamentally alter the way younger people use Facebook and Instagram.

Proposals include restrictions on features designed to encourage continued engagement, including infinite scrolling and notifications. The states are also seeking changes to recommendation systems so that the wellbeing of younger users is prioritised over engagement.

Other measures being sought include stronger age restrictions, limits on the amount of time younger people spend on the platforms and the deletion of algorithms and artificial intelligence models developed using children's data.

Such changes could have implications beyond Meta.

Thousands of legal claims have been brought against social media businesses in the US, including claims involving Meta, TikTok, YouTube and Snapchat. The cases generally centre on allegations that platforms were deliberately designed to encourage prolonged use by children and contributed to problems including depression, anxiety and body-image concerns. The companies have denied allegations that their products caused these harms.

Previous Rulings

The latest case follows other significant legal action concerning Meta's treatment of younger users.
In New Mexico, a court recently imposed penalties approaching $1 billion and ordered changes to Meta's platforms. These included removing visible like counts for users under 18, restricting the sending and receiving of nudity by teenagers and limiting push notifications during certain hours.

The New Mexico court also found Meta's platforms constituted a "public nuisance", linking their operation to wider concerns about the effect of social media on young people's wellbeing.

Meta has said it will appeal against that ruling.

Why the Case Matters

The case represents one of the most significant legal tests yet of how responsibility for protecting children should be applied to the design of social media platforms.

At issue is not simply the content young people encounter online, but the way the platforms themselves are designed. Features such as likes, autoplay, notifications, recommendation algorithms and infinite scrolling are increasingly coming under scrutiny over whether they encourage excessive or compulsive use.

The outcome could therefore influence how technology companies design services for younger users in the US and potentially contribute to the wider international debate over children's online safety.

More Information

Further information is available from recent reporting from Reuters on the US states' case against Meta at:
https://www.reuters.com/business/meta-29-states-head-court-biggest-test-yet-youth-social-media-litigation-2026-08-12/

Would you Recognise Sexual Harassment at Work & Know How to Respond?

Sexual harassment is not always obvious. It can include comments, jokes, gestures, unwanted attention, physical behaviour or digital communications, and a single incident can be enough. Behaviour dismissed as flirting, humour or "banter" may be unwanted and leave someone feeling intimidated, humiliated or uncomfortable.

Everyone has a role in recognising inappropriate behaviour and maintaining respectful workplace standards, while managers have additional responsibilities for responding to concerns and taking appropriate action. Employers also have a legal duty to take reasonable steps to prevent sexual harassment – making awareness, early intervention and effective management increasingly important.

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Core information that everyone needs to know

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Sexual Harassment Awareness for Managers

Information that managers and supervisors need to know

- 100% Online Course
- CPD Assured
- Immediate Start
- Self-Paced Learning
- All Course Materials Included
- Final Assessment Included
- Digital Certificate Included
- No Hidden Charges
- £15+VAT Per User
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