

Company Fined After Collapsing Stockpile Injured Two Members of the Public



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Company Fined After Collapsing Stockpile Injured Two Members of the Public

Summary

A scrap metal recycling company has been fined £40,000 after two members of the public were injured when a large stockpile of scrap metal collapsed onto them at a site in Scunthorpe. An investigation found that the company had failed to adequately segregate pedestrians from moving machinery and unstable stockpiles, despite an earlier near miss involving the same excavator.



The scrap yard with an unstable metal pile

What Happened

On 6 February 2025, a father and son were unloading scrap metal at a recycling facility while a 360-degree excavator fitted with a grab attachment was operating nearby.

As the excavator removed material from a large stockpile, part of the pile collapsed, causing heavy pieces of scrap metal to fall onto both individuals. Both were taken to hospital, with one sustaining a broken leg.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the excavator had been operating close to members of the public for approximately 20 minutes before the incident.

The company had failed to implement suitable controls to protect pedestrians from the hazards associated with moving machinery and unstable stockpiles.

The investigation also identified an earlier near miss, on 27 January 2025, when the rotating cab of the same excavator struck a vehicle belonging to a member of the public who was unloading scrap metal. Although nobody was injured during the earlier incident, the underlying safety failures had not been addressed.

The Outcome

The company pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £40,000 and ordered to pay £6,181 in costs.

Following the incident, HSE issued a Prohibition Notice preventing the excavator from operating near pedestrians. The company subsequently introduced several improvements, including a separate public unloading area, additional signage, supervised unloading arrangements, a traffic management plan and barriered pedestrian walkways.

Additional Context

Section 3(1) of the Health and Safety at Work etc. Act 1974 requires employers to conduct their undertakings in a way that ensures, so far as is reasonably practicable, that people who are not employees are not exposed to risks to their health and safety.

HSE guidance emphasises the importance of separating pedestrians from moving vehicles and machinery wherever reasonably practicable.

Waste and recycling facilities present particular challenges because of the interaction between heavy machinery, unstable materials, workers and visiting members of the public.

Effective traffic management, designated unloading areas and suitable pedestrian segregation are essential measures for controlling these risks.

Key Learning Points

- Segregate pedestrians from moving vehicles and machinery wherever reasonably practicable.
- Ensure stockpiles are stable and that people are protected from falling or collapsing materials.
- Establish designated unloading areas that keep members of the public away from hazardous operations.
- Develop and implement suitable workplace transport and traffic management arrangements.
- Ensure operators maintain safe distances from pedestrians when using mobile plant and machinery.
- Investigate near misses promptly and implement corrective actions to prevent future incidents.
- Regularly review risk assessments and control measures, particularly where members of the public may be exposed to workplace hazards.
- Provide appropriate supervision, signage and physical barriers to maintain safe working arrangements.

More Information

HSG136 – A Guide to Workplace Transport Safety
<https://www.hse.gov.uk/pubns/priced/hsg136.pdf>

HSE – Workplace Transport Safety
<https://www.hse.gov.uk/workplacetransport>

HSE – Waste Management and Recycling
<https://www.hse.gov.uk/waste>



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Employee Suffered Serious Injuries After Unsafe Stepladder Collapsed

Summary

A local authority was fined £6,000 after an employee suffered a fractured collarbone and broken ribs when a stepladder collapsed beneath him.



What Happened

The employee was attempting to access a loft space at a council-operated site in Wirral. As he approached the top of a stepladder, it collapsed, causing him to fall to the ground. He sustained a fractured collarbone and broken ribs.

The Investigation

The Health and Safety Executive (HSE) investigation identified several shortcomings in the council's management of work at height activities. Defective ladders had been identified but remained accessible to employees. Ladder use was not adequately controlled, and employees had not received appropriate training on how to assess whether ladders were safe to use.

The Outcome

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

It was fined £6,000 and ordered to pay £4,000 in costs.

Key Learning Points

- Remove defective equipment: Damaged or unsafe ladders must be taken out of use immediately and prevented from being used.
- Conduct pre-use checks: Ladders should be checked for visible defects before use.
- Provide appropriate training: Employees must understand how to use ladders safely and recognise defects.
- Manage work at height: Employers must assess risks, select suitable access equipment and implement appropriate controls.

More Information

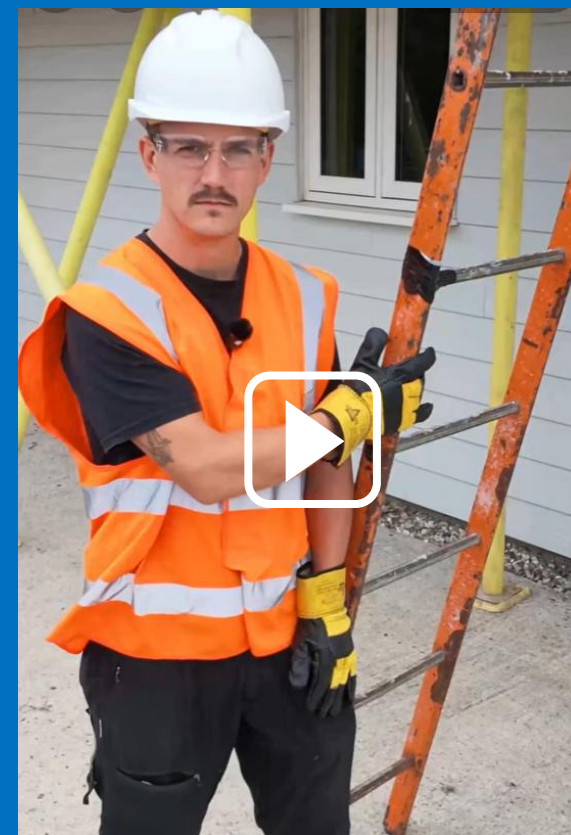
Working at Height:

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

Ladders and Stepladders:

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

Ladder safety on our social media



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Corroded Pipework Caused Five Leaks of Highly Flammable Gas at Chemical Plant

Summary

A chemical company has been fined £267,000 after inadequate inspection and maintenance arrangements resulted in five separate leaks of highly flammable hydrocarbons at a chemical processing plant in Scotland. An investigation by the Health and Safety Executive (HSE) found significant failures in the management of corrosion risks, potentially exposing workers, contractors and the surrounding environment to catastrophic consequences.

What Happened

Between February 2018 and September 2019, five leaks occurred in insulated pipework at a chemical processing plant in Fife.

The leaks involved highly flammable substances, including ethane and dimethyl sulphide (DMS), and were caused by corrosion beneath the pipe insulation.

One incident resulted in an estimated 82 tonnes of hydrocarbons escaping into the atmosphere over approximately six weeks.

During a routine inspection in May 2019, HSE inspectors detected a strong smell of DMS and discovered that a pipe had been leaking for approximately four months. Despite knowing about the leak, the company had continued operating without implementing additional precautions.

The plant was classified as an Upper Tier establishment under the Control of Major Accident Hazards (COMAH) Regulations 2015, reflecting the potential for major accidents involving dangerous substances.

The Investigation

The HSE investigation identified serious shortcomings in the company's arrangements for managing corrosion under insulation (CUI).

Inspections relied heavily on visual checks, sometimes conducted from ground level several metres away. Insulation was not always removed, limiting the ability to identify deterioration beneath it.

The company used a risk-ranking system to determine which pipes required further investigation. However, inadequate initial inspections meant that potentially dangerous corrosion could remain undetected. Despite repeated leaks, the company failed to recognise and address these weaknesses until HSE intervention. Inspectors issued enforcement notices requiring improvements, and subsequent investigations identified further leaks.

The Outcome

The company pleaded guilty to breaching Regulation 6(2) of the Provision and Use of Work Equipment Regulations 1998 and section 33(1)(c) of the Health and Safety at Work etc. Act 1974.

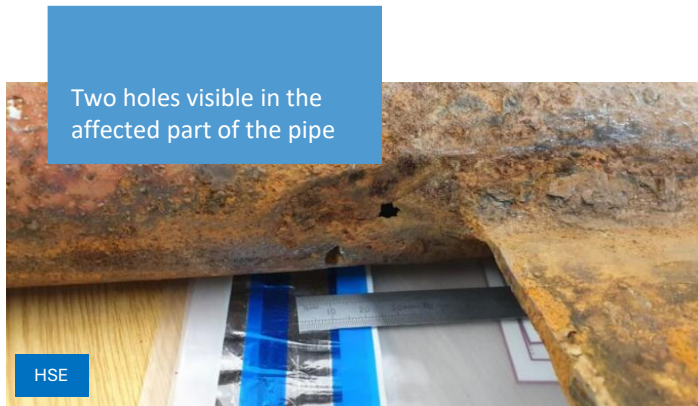
It was fined £267,000.

Although none of the leaks resulted in a major accident, HSE emphasised that the consequences could have been significantly more serious.

Additional Context

Corrosion under insulation is a recognised hazard in industrial facilities. Moisture penetrating insulation can cause hidden deterioration of pipework, potentially leading to the uncontrolled release of hazardous substances. At high-hazard establishments, effective inspection, maintenance and risk management arrangements are essential to preventing major accidents.

The incident highlights the importance of ensuring inspection methods are capable of identifying deterioration, rather than relying on visual assessments that may fail to detect hidden defects.



Key Learning Points

- Insulated pipework must be inspected and maintained using methods capable of detecting hidden corrosion.
- Risk assessments and inspection programmes should reflect the hazards associated with the substances being processed.
- Known leaks of hazardous substances must be addressed promptly, with appropriate precautions implemented.
- Repeated equipment failures should trigger a review of existing inspection and maintenance arrangements.
- High-hazard facilities must maintain effective systems to prevent the uncontrolled release of dangerous substances.

More Information

Provision and Use of Work Equipment Regulations 1998 (PUWER):

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



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Cybersecurity Update – Protecting Our Customers



Recent news reports have highlighted serious cybersecurity vulnerabilities affecting PHP, a programming language widely used to power websites and online platforms. These vulnerabilities have raised concerns because, if left unaddressed, they could potentially allow cybercriminals to compromise affected systems, access sensitive information or disrupt online services.

At HSQE Ltd, we take cybersecurity seriously and continually monitor emerging threats to ensure our systems remain secure and up to date. In response to the recently identified vulnerabilities with PHP, our technical team acted promptly to apply the latest security updates, helping to protect our systems and the customers who rely on our online learning platform, VitalSkills.co.uk.

Cybersecurity is an ongoing responsibility, and no system can ever be completely immune to threats. However, by remaining vigilant, maintaining our systems and responding quickly to emerging risks, we aim to minimise vulnerabilities and maintain a secure and reliable learning environment.

Protecting our customers' information and maintaining their trust remain key priorities for HSQE Ltd.

Worker Suffered Multiple Fractures After Arm Became Trapped in Unguarded Conveyor

Summary

A baked goods manufacturer has been fined £333,333 after an employee suffered multiple fractures when her arm became trapped in a rotating conveyor roller during cleaning operations at a food manufacturing facility in Kent. An investigation by the Health and Safety Executive (HSE) identified failures to prevent access to dangerous moving parts of machinery.

What Happened

On 1 December 2023, an employee was cleaning a sausage roll production line at a food manufacturing facility. Although the conveyor had initially been switched off, it unexpectedly began operating while the employee was cleaning it.

As she passed her hand through an unguarded conveyor roller, her arm became entangled in the rotating mechanism and was pulled into the machinery. The incident resulted in multiple fractures, including a broken arm.

The Investigation

The HSE investigation found that the manufacturer had failed to implement effective measures to prevent access to the dangerous rotating parts of the conveyor system. The machinery was not adequately guarded, allowing the employee to come into contact with moving components during cleaning activities.

Under the Provision and Use of Work Equipment Regulations 1998 (PUWER), employers must take effective measures to prevent access to dangerous parts of

machinery. This will normally involve fixed guards. Where routine access is necessary, interlocked guards may be required to ensure dangerous machinery cannot operate while access is possible.

The Outcome

The manufacturer pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998.

The company was fined £333,333 and ordered to pay £7,644 in costs.

Additional Context

Conveyor systems are widely used throughout the food manufacturing industry, but their moving parts can present significant entanglement, trapping and crushing hazards. Cleaning, maintenance and blockage removal activities can be particularly hazardous when workers need to access areas close to moving machinery.

Key Learning Points

- Ensure all dangerous moving parts of machinery are adequately guarded to prevent accidental contact.
- Use fixed guards wherever practicable and interlocked guards where routine access to hazardous areas is necessary.
- Establish and enforce safe isolation procedures before cleaning, maintenance or other activities involving access to dangerous machinery.
- Prevent machinery from restarting unexpectedly while employees are working in hazardous areas.
- Conduct suitable and sufficient risk assessments covering routine production, cleaning, maintenance and foreseeable abnormal operations.
- Provide employees with appropriate information, instruction and training on machinery hazards and safe working procedures.
- Regularly inspect machinery guarding and safety devices to ensure they remain effective.



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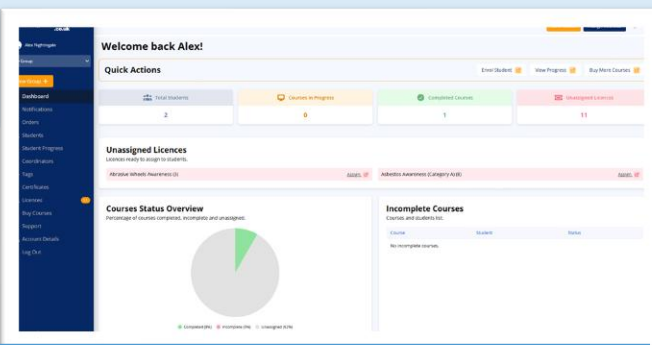
As the owners and operators of VitalSkills.co.uk, we've drawn on years of training experience and customer feedback to shape our next-generation learning platform. LMS-3 builds on the existing system, introducing new features and improvements to how our customers purchase, manage and complete their courses.



Making Training Management Easier

For organisations managing employee training, LMS-3 introduces a refreshed dashboard, enhanced learner management and clearer visibility of training progress.

From purchasing courses and allocating licences to monitoring completions and accessing certificates, our aim remains making training management as straightforward as possible.



Preview of the new LMS-3 coordinator dashboard

An Enhanced Experience for Students

Students will benefit from a refreshed learning environment, with updated navigation and a more intuitive experience, making it even easier to access their courses, track their progress and complete their training.

Refreshed Courses, Same expertise.

While the platform is changing and our courses are getting a makeover, our commitment to quality remains the same.

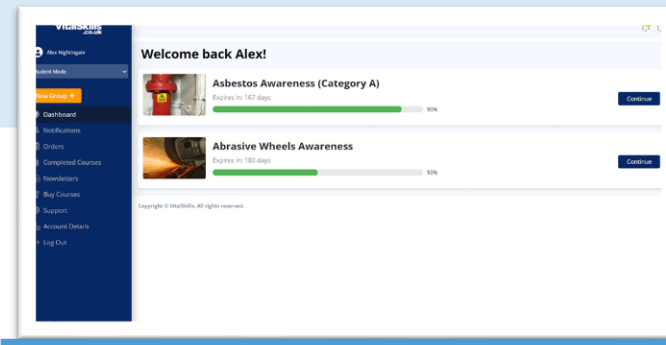
Our courses continue to be created and maintained by our own in-house Subject Matter Experts (SMEs), giving us direct control over their content, quality and ongoing development.

Coming Soon

We're now in the final stages of development and testing, working to ensure the new platform is ready for launch.

We'll be sharing further updates on social media, including previews of the new system and information about what to expect, as we approach launch.

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Preview of the new LMS-3 Student Dashboard



Preview of the new LMS-3 student learning experience



Unguarded Conveyor Led to Worker Suffering Hand Injuries

Summary

A chemical manufacturer has been fined £100,000 after an employee suffered hand injuries when his hand became entangled in an unguarded conveyor.

The incident highlights the importance of ensuring effective measures are in place to prevent access to dangerous moving parts of machinery.

What Happened

On 24 April 2024, an employee was working at a chemical manufacturing site in Thetford when he removed a cardboard box from a running conveyor.

His hand became entangled in an unguarded part of the machinery, resulting in a broken finger and bruising to three other fingers. He required surgery and was unable to work for six weeks.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to prevent access to dangerous parts of machinery.

The powered conveyor linked two pieces of handling equipment within the site's packaging area and was not adequately guarded to prevent employees from coming into contact with moving parts.

HSE guidance states that employers must take effective measures to prevent access to dangerous parts of machinery. This will normally involve fixed guards. Where routine access is necessary, interlocking guards may be required to stop dangerous parts before a person can reach the danger zone.

The Outcome

The company pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998 (PUWER). It was fined £100,000 and ordered to pay £6,468.18 in costs.

Key Learning Points

- Dangerous moving parts of machinery must be adequately guarded to prevent access.
- Fixed guards should normally be used where access to dangerous parts is not required.
- Where routine access is necessary, suitable interlocking guards may be required.
- Employers should ensure machinery risks are properly assessed and appropriate safeguards remain effective during normal operations.
- Employees should not be able to reach dangerous moving parts while machinery is operating.

Additional Context

Regulation 11 of PUWER requires employers to take effective measures to prevent access to dangerous parts of machinery or to stop the movement of dangerous parts before any part of a person enters a danger zone.

Machinery guarding is an important part of controlling risks from work equipment, particularly where employees work close to conveyors, rollers, drive mechanisms and other moving components.

More Information

The Provision and Use of Work Equipment Regulations 1998 (PUWER) are available from:
<https://www.legislation.gov.uk/uksi/1998/2306/contents/made>

An overview on the regulations is available from the HSE at:
<https://www.hse.gov.uk/work-equipment-machinery/puwer-overview.htm>



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Overloaded Floor Collapsed Leaving Bricklayer with Multiple Fractures

Summary

A construction company has been fined after a 25-year-old bricklayer suffered multiple fractures when an upper floor collapsed beneath him at a house under construction in Oldham. The floor had been overloaded with concrete blocks and had not been constructed in accordance with the manufacturer's design.

What Happened

The bricklayer was working on the upper level of the property when the floor suddenly collapsed. He fell with multiple concrete blocks that had been stored on the floor. He sustained fractures to his right leg, hip and left hand. His injuries required surgery and resulted in him spending a month in hospital.

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 construction work. The floor had been overloaded with concrete blocks and had not been constructed in accordance with the manufacturer's design.

HSE also identified several other health and safety failings, including:

- Unsafe scaffolding.
- Inadequate arrangements for working at height.
- A lack of fire alarms.
- Inadequate competent site management.

HSE inspectors issued multiple enforcement notices as a result of the failings.

The Outcome

The company pleaded guilty to breaching Regulation 13(1) of the Construction (Design and Management) Regulations 2015. It was fined £30,000 and ordered to pay £4,883 in costs.

Key Learning Points

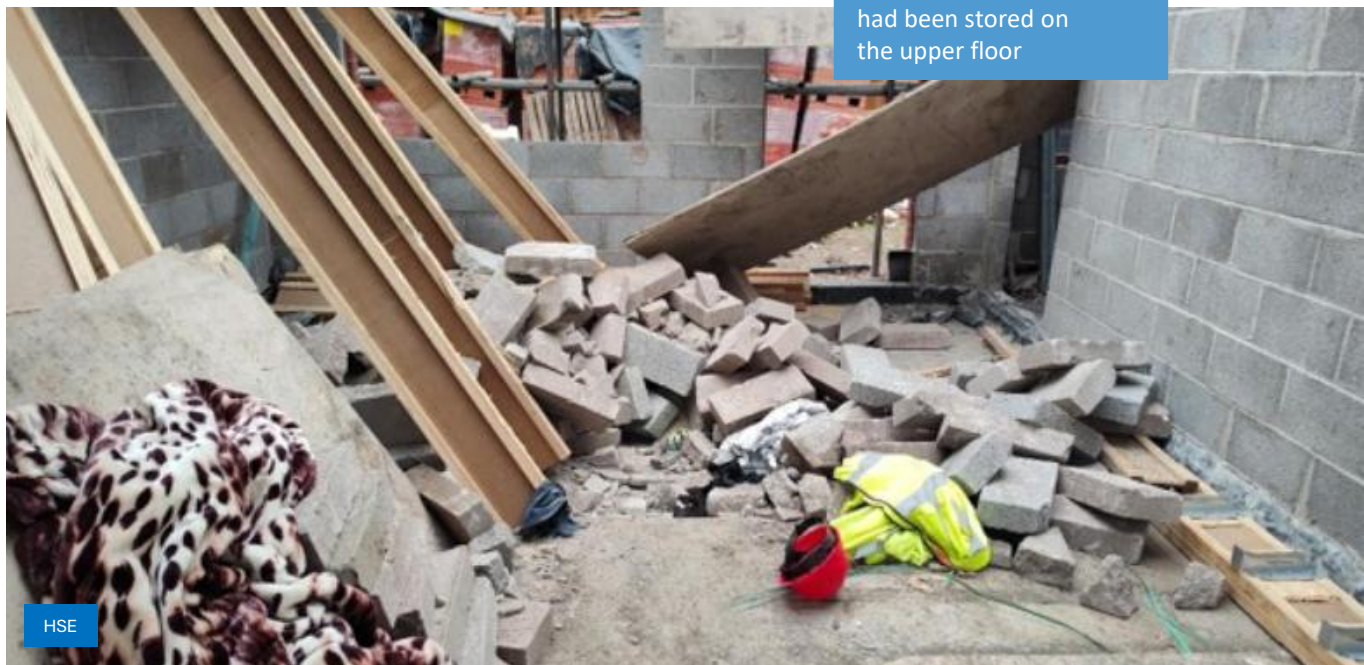
- Temporary and partially completed structures must be capable of supporting the loads placed upon them.
- Materials should be stored in locations where their weight will not overload floors or other structures.
- Construction work must follow relevant designs and manufacturers' specifications.
- Principal contractors must effectively plan, manage and monitor the construction phase.
- Suitable site supervision and competent management are essential for identifying and controlling risks.

Additional Context

Principal contractors have a key role under the Construction (Design and Management) Regulations 2015. They must plan, manage and monitor the construction phase and ensure appropriate preventative and protective measures and supervision are in place.

More Information

HSE provides guidance on managing health and safety in construction, including the duties of principal contractors and the management of construction risks.



HSE



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Company Fined After Ignoring HSE Enforcement Notices

Summary

A manufacturing company has been fined after repeatedly failing to comply with Health and Safety Executive (HSE) Improvement Notices requiring it to control exposure to hazardous welding fumes and provide hearing health surveillance for workers exposed to excessive noise. Despite multiple follow-up inspections, the company failed to take the required action, leaving employees at risk of serious long-term health conditions.

What Happened

During an inspection in August 2024, the HSE identified a number of health and safety failings at the company's premises. These included employees carrying out mild steel welding without suitable local exhaust ventilation (LEV), inadequate welfare facilities and a failure to assess the risks associated with workplace noise.

HSE inspectors served several Improvement Notices requiring the company to address these issues. However, subsequent inspections found that the company had failed to comply with the notices relating to welding fume control and health surveillance for employees exposed to high levels of noise.

As a result, workers continued to be exposed to hazardous welding fumes and excessive workplace noise without appropriate protection or monitoring.

The Investigation

HSE's investigation found that the company had failed to implement suitable control measures to protect employees from exposure to carcinogenic welding fumes. Suitable local exhaust ventilation was not provided, and there was no adequate respiratory protective equipment (RPE) where

exposure remained uncontrolled.

The investigation also established that the company had failed to provide hearing health surveillance for employees regularly exposed to high noise levels. Health surveillance is intended to detect early signs of hearing damage, helping employers intervene before permanent hearing loss occurs and confirming whether existing noise control measures are effective.

The Outcome

The company was found guilty of failing to comply with two Improvement Notices issued by the Health and Safety Executive (HSE), contrary to Section 33(1)(g) of the Health and Safety at Work etc. Act 1974.

It was fined £30,000 and ordered to pay £4,571 in costs together with a £2,000 victim surcharge.

Additional Context

The International Agency for Research on Cancer (IARC) classifies exposure to mild steel welding fumes as carcinogenic to humans, with evidence linking long-term exposure to lung cancer and possible kidney cancer. Employers must ensure effective controls are in place whenever welding is undertaken, whether indoors or outdoors.

Where local exhaust ventilation alone cannot adequately control exposure, suitable respiratory protective equipment should also be provided.

The Control of Noise at Work Regulations 2005 also require employers to provide hearing health surveillance where employees are regularly exposed to hazardous levels of noise or are particularly susceptible to hearing damage.

Key Learning Points

- Ensure effective local exhaust ventilation is provided for

all welding activities.

- Provide suitable respiratory protective equipment where ventilation alone is insufficient.
- Assess workplace noise risks and implement appropriate control measures.
- Carry out hearing health surveillance for employees regularly exposed to high levels of noise.
- Respond promptly to HSE Enforcement Notices and complete all required improvements within the specified timescales.
- Regularly review control measures to ensure they continue to protect workers from long-term occupational health risks.

More Information

Relevant guidance can be found at:

[Safety Bulletin 15: HSE Guidance welding fume 2019](#)

[Welding fume control](#) (PDF)

[L108: Controlling noise at work](#) (PDF)

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Worker Suffered Life-Changing Injuries After 1.2-Tonne Crate Fell from Forklift Truck

Summary

A medical equipment business in Hull was fined £230,000 after an employee of a delivery company suffered life-changing injuries when a 1.2-tonne crate fell from a forklift truck during an unloading operation.

An investigation by the Health and Safety Executive (HSE) found that the unloading operation had not been adequately assessed, planned, controlled or supervised.

What Happened

A 64-year-old delivery worker was delivering a large crate containing an electron microscope to a medical equipment business in Hull.

The delivery company had originally intended to provide a forklift truck and driver to unload the equipment. However, due to COVID-19 restrictions, the receiving business decided to reduce the number of people on site and took responsibility for unloading the crate.

During the unloading operation, the worker was positioned in an unsafe location when the crate, weighing approximately 1.2 tonnes, fell from the forklift truck and landed on him.

The worker sustained life-changing injuries.

The Investigation

The HSE investigation identified significant failures in the planning and management of the unloading operation.

The receiving business had failed to adequately assess the

risks associated with unloading the heavy crate or establish a safe system of work.

The investigation found that the company had not properly considered how the lifting operation should be undertaken, who should be involved or what precautions were necessary to protect those in the vicinity. Furthermore, the operation was not meaningfully controlled or supervised, allowing the delivery worker to remain in a dangerous position during the lift.

These failures exposed the worker to foreseeable risks associated with moving heavy loads using lifting equipment.

The Outcome

The company was found guilty of breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was fined £230,000 and ordered to pay £111,000 in costs. The total financial penalty amounted to £341,000.



The fallen crate at the side of the truck

Additional Context

Lifting operations involving heavy or unstable loads present significant risks, particularly where people are working close to moving equipment or suspended loads.

Under the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), lifting operations must be properly planned by a competent person, appropriately supervised and carried out safely.

The level of planning and supervision required should reflect the complexity of the operation and the risks involved.

Where deliveries involve multiple organisations, responsibilities for unloading should be clearly established and appropriate arrangements agreed before work begins. Changes to established delivery arrangements, including decisions to use different equipment or personnel, should trigger a review of the associated risks and necessary precautions.

Key Learning Points

- Ensure all lifting operations are properly assessed, planned and supervised by competent people.
- Establish clear responsibilities between delivery companies and receiving organisations before unloading begins.
- Assess the weight, dimensions, stability and handling requirements of loads before lifting.
- Select suitable lifting equipment and ensure it is operated by appropriately trained and competent personnel.
- Establish safe systems of work that prevent people from entering areas where they could be struck or crushed by falling loads.
- Review risk assessments and working arrangements whenever established procedures are changed.
- Ensure effective communication and coordination between everyone involved in lifting and unloading operations.
- Never allow operational pressures or changes in working arrangements to compromise essential safety precautions.



Maintenance Engineer Suffered Life-Changing Injuries After Arm Was Trapped in Unguarded Conveyor

Summary

An animal feed manufacturer has been fined £160,000 after a maintenance engineer suffered life-changing injuries when his arm became trapped in an unguarded conveyor.

The incident occurred while the engineer was attempting to clear a blockage from moving machinery. An investigation revealed that unsafe modifications had allowed workers access to dangerous machinery parts for several years.

What Happened

A maintenance engineer was working a nightshift at an animal feed manufacturing facility in Merseyside when he was asked to investigate a conveyor problem.

While the conveyor was running, he reached through an opening in its casing to remove accumulated material. His arm was drawn into the moving machinery, causing catastrophic injuries to his forearm and hand, including fractures and extensive degloving injuries.

The engineer was working alone, with no emergency stop button nearby. He repeatedly waved towards a CCTV camera in an attempt to attract attention, but nobody responded. After approximately 40 seconds, he managed to free his arm.

He subsequently required multiple operations and blood transfusions and continues to receive specialist treatment.

His injuries have prevented him from returning to work.

The Investigation

An investigation by the Health and Safety Executive (HSE) identified significant failures in machinery safety arrangements.

Investigators found that:

- An opening had been deliberately cut into the conveyor casing several years earlier to allow workers to clear blockages while the machinery remained operational.
- Dangerous moving parts were accessible because suitable guarding was not provided.
- There was no emergency stop button in the immediate area.
- A second conveyor had a similar unauthorised access opening.
- Routine inspections, management walkarounds and audits had failed to identify or address these longstanding hazards.
- The company's established safe systems of work required machinery to be guarded and isolated before maintenance or cleaning, but these requirements were not being followed.

Following the incident, the company installed a fixed mesh guard and an emergency stop button.

The Outcome

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

It was fined £160,000 and ordered to pay £4,728 in costs.

Additional Context

The Provision and Use of Work Equipment Regulations 1998 (PUWER) require employers to take effective measures to prevent access to dangerous parts of machinery.

Machinery should be appropriately guarded, and suitable isolation procedures must be followed before maintenance, cleaning or blockage removal where exposure to dangerous moving parts could occur.

Emergency stop devices provide an additional safety measure but are not a substitute for effective guarding and isolation.

Key Learning Points

- Ensure all dangerous moving parts of machinery are adequately guarded to prevent access.
- Never attempt to clear blockages or carry out maintenance on moving machinery where there is a risk of contact with dangerous parts.
- Establish and enforce safe isolation procedures before maintenance, cleaning or blockage removal.
- Ensure machinery modifications are properly assessed, authorised and inspected to prevent the introduction of new hazards.
- Conduct effective workplace inspections and audits that identify unsafe conditions and practices.
- Provide suitable emergency stop devices where required and ensure they are readily accessible.
- Assess the additional risks associated with lone working, particularly during maintenance activities.
- Ensure employees receive appropriate training and supervision and follow established safe systems of work.

More Information

HSE – PUWER Overview

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

HSE – Introduction to Machinery Safety

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

HSE – Maintenance of Work Equipment

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

HSE – Managing the Risks of Working Alone

<https://www.hse.gov.uk/lone-working/employer/manage-the-risks-of-working-alone.htm>



Fall From Loading Ramp Led to Worker's Death

Summary

A company has been fined £425,000 after a warehouse supervisor suffered fatal injuries when he fell from a mobile loading ramp during a container loading operation.

The 60-year-old worker fell approximately 1.5 metres onto a concrete surface after stepping backwards when a bale being moved by a forklift truck slipped.

What Happened

The worker was helping to load plastic waste bales into a shipping container at a site in Middlesbrough.

As he accessed the mobile loading ramp, a plastic bale slipped from the forklift truck being used to load the container. This caused him to step backwards and fall approximately 1.5 metres from the ramp onto the concrete surface below.

He suffered serious injuries and died in hospital several weeks later.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the company had failed to properly assess the risks associated with the loading operation or adequately control the risks arising from pedestrians using the mobile loading ramp.

Employees had been permitted to use the ramp without handrails, despite the manufacturer specifically advising that pedestrians should not use it unless handrails were fitted.

HSE also found that reasonably practicable alternatives that could have avoided work at height had not been sufficiently considered. These included using existing loading bays or

placing shipping containers on the ground before loading. The loading operation was a new activity, highlighting the importance of reassessing risks whenever established working practices change.

The Outcome

The company was found guilty of breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and Regulations 4(1)(a) and 6(2) of the Work at Height Regulations 2005.

Following a trial, the company was fined £425,000 and ordered to pay costs of £119,258.

Key Learning Points

- Avoid work at height wherever it is reasonably practicable to do so.
- Properly assess and plan activities where workers could be exposed to a risk of falling.
- Follow manufacturers' safety instructions when using work equipment.
- Provide suitable fall prevention measures, such as handrails, where required.
- Consider safer alternatives that could eliminate the need for people to work at height.
- Review risk assessments whenever new activities or changes to established working practices are introduced.

Additional Context

Employers must ensure that work at height is properly planned, appropriately supervised and carried out safely. Where work at height cannot reasonably be avoided, suitable measures must be taken to prevent falls and protect workers from injury. Falls from relatively low heights can result in serious or fatal injuries, particularly where a person falls onto a hard surface.

More Information

The HSE's Brief Guide to Working at Height can be accessed at: <https://www.hse.gov.uk/pubns/indg401.htm>



The mobile ramp from where the man fell



Unguarded Machinery Led to Worker Being Crushed to Death

Summary

A cement company has been fined £1 million after an employee was killed when he was crushed by machinery at a cement bagging plant.

The 35-year-old worker was found crushed beneath a 1.6-tonne concrete weight used as part of equipment for raising pallets loaded with 25 kg bags of cement.

What Happened

The incident occurred in August 2021 at a cement facility in Gloucestershire.

The worker was operating in the cement bagging plant when he was crushed by the 1.6-tonne concrete weight. He sustained fatal injuries.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that a large section of perimeter fencing around the equipment had routinely been removed over a prolonged period.

This allowed unrestricted access to dangerous parts of the machinery, including moving components capable of causing serious injury or death.

HSE found that the company had failed to prevent employees from accessing these dangerous parts of the machinery, despite suitable safeguards being available. HSE guidance states that employers must take effective measures to prevent access to dangerous parts of machinery. Wherever possible, this should be achieved using fixed guards.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £1 million and ordered to pay £9,621 in costs.

HSE said the incident should never have happened and that suitable guarding could have prevented the worker's death.

Key Learning Points

- Dangerous parts of machinery must be effectively guarded to prevent access.
- Fixed guards should be used wherever practicable.
- Guards and perimeter fencing must not be routinely removed or bypassed.
- Employers should ensure machinery safeguards remain effective throughout the equipment's operation.
- Unsafe practices that develop over time must be identified and addressed before they become accepted ways of working.
- Failure to control access to dangerous machinery can have fatal consequences.

More Information

Further information on machinery safety and guarding is available from the Health and Safety Executive (HSE) at: <https://www.hse.gov.uk/pubns/priced/l22.pdf>



The unguarded concrete weight

HSE



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Fish Processing Company Fined £420,000 After Worker Suffered Multiple Fractures and Collapsed Lungs

Summary

A fish processing company has been fined £420,000 after a supervisor suffered life-threatening injuries when he became trapped in a palletising machine. An investigation by the Health and Safety Executive (HSE) identified serious failures in machinery guarding, maintenance and safe working procedures.

What Happened

On 10 October 2024, a 41-year-old forklift supervisor was called to clear a blockage in a palletising machine at a fish processing facility in Lerwick, Shetland.

The machine's interlocking safety gate had become difficult to open following earlier damage. Instead of using the gate, the supervisor removed a loose section of perimeter fencing and entered the machinery area without isolating the power supply.

While walking along a stationary conveyor towards the blockage, he activated a sensor that restarted the machine. He was repeatedly struck by the machine's moving pushers until a colleague activated the emergency stop. The supervisor suffered eight fractured ribs, multiple pelvic fractures, a fractured collarbone, a fractured shoulder blade and two collapsed lungs.

He required hospital treatment, spending 10 days in intensive care and a further 10 days in a high dependency unit before undergoing rehabilitation. His injuries have had a significant impact on his life, and he has indicated that he does not wish to return to his previous role.

The Investigation

An investigation by the HSE identified significant failures in the management of machinery safety.

The palletising machine was surrounded by perimeter fencing incorporating an interlocking safety gate designed to isolate the machinery's power supply when opened. However, the gate had been damaged by a forklift truck earlier in 2024, affecting its locking mechanism and making it difficult to operate.

The investigation established that:

- A damaged section of perimeter fencing had become insecure, allowing access to dangerous machinery.
- Employees had developed a practice of removing the loose fencing panel to clear frequent blockages.
- Machinery was being accessed without first isolating its power supply.
- The company's arrangements had failed to prevent employees from bypassing essential safety measures.

These failures exposed employees to dangerous moving machinery and created a foreseeable risk of serious injury.

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).

It was fined £420,000, together with a victim surcharge of £31,500, bringing the total financial penalty to £451,500.

Following the incident, the company reinstated the perimeter fencing to ensure that the interlocking safety gate was the only means of accessing the machine. It also updated its safety procedures to prohibit employees from bypassing machinery safety barriers.

Additional Context

Regulation 11 of PUWER requires employers to take effective measures to prevent access to dangerous parts of

machinery or stop their movement before any person enters a danger zone.

Where machinery regularly becomes blocked, employers must establish safe procedures for clearing obstructions. These should include appropriate isolation arrangements to prevent unexpected start-up.

Damaged guards, defective interlocks and unsafe working practices must be addressed promptly rather than allowed to become accepted methods of working.

Key Learning Points

- Ensure all dangerous moving parts of machinery are adequately guarded to prevent access during operation.
- Inspect and maintain machinery guards, interlocks and safety devices to ensure they remain effective.
- Remove defective machinery from use, or implement effective alternative controls, until safety-critical defects have been rectified.
- Never bypass, remove or defeat machinery guards or interlocking safety devices to gain access to dangerous parts.
- Establish safe procedures for clearing blockages, including isolating machinery and preventing unexpected start-up.
- Investigate recurring machinery blockages and address their underlying causes.
- Provide employees with appropriate information, instruction, training and supervision.
- Monitor working practices to identify and address unsafe shortcuts before they become routine.

More Information

HSE – Work Equipment and Machinery
<https://www.hse.gov.uk/work-equipment-machinery/>

HSE – Provision and Use of Work Equipment Regulations 1998 (PUWER)
<https://www.hse.gov.uk/work-equipment-machinery/puwer.htm>



House Builder Fined £300,000 After Worker Suffered Life-Changing Spinal Injuries in Fall Through Stairwell Opening

Summary

A house-building company has been fined £300,000 after a 24-year-old labourer suffered life-changing spinal injuries when he fell through an unprotected stairwell opening at a construction site in West Yorkshire.

An investigation by the Health and Safety Executive (HSE) found that the company had failed to adequately plan and supervise work at height or implement suitable measures to prevent falls.

What Happened

In January 2024, a temporary labourer was working at a construction site where four new homes were being built.

The worker, who was in only his second week on the job, stepped backwards and fell approximately one storey onto a concrete surface through an opening intended for a staircase that had not yet been installed.

The stairwell opening had previously been loosely covered with scaffold boards, but these had been removed. No suitable covering or edge protection was in place to prevent a fall.

The worker lost consciousness following the fall and had to be rescued by emergency services because there was no alternative means of accessing the area below.

He sustained serious spinal injuries that prevented him from working for several months. He has not returned to physically demanding employment since the incident.

The Investigation

The HSE investigation identified significant failures in the management of work at height.

The company had failed to ensure that work was properly planned and appropriately supervised. It had also failed to implement suitable and sufficient measures to prevent workers falling through the unprotected stairwell opening.

The absence of secure coverings or suitable edge protection exposed workers to a foreseeable risk of serious injury.

HSE guidance emphasises that work at height must be properly planned, supervised and carried out by competent people. Employers must assess the risks and implement appropriate precautions, prioritising collective protection measures such as guardrails and secure coverings.

The Outcome

The company was found guilty of three offences relating to failures to properly plan and supervise work at height and implement suitable measures to prevent falls. It was fined £300,000 and ordered to pay £9,284.05 in costs.

Key Learning Points

- Ensure all work at height is properly planned, risk assessed and appropriately supervised.
- Identify and assess the risks associated with floor openings, stairwells and other unprotected edges.
- Install suitable collective protection measures, such as securely fixed covers or guardrails, to prevent falls.
- Ensure temporary coverings are adequately secured, capable of supporting foreseeable loads and not removed without suitable alternative protection.
- Regularly inspect work areas to identify changes that could introduce additional fall hazards.
- Ensure workers receive appropriate information, instruction and training about the risks associated with working at height.
- Provide safe access and emergency arrangements for all areas where work is undertaken.

More Information

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



The uncovered opening



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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