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Newsletter | November 2026

HSE Have Announced Changes to Strengthen Asbestos Safety Regulations



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HSE Have Announced Changes to Strengthen Asbestos Safety Regulations

Summary
The Health and Safety Executive (HSE) has announced changes to the Control of Asbestos Regulations 2012 (CAR 2012), following a consultation aimed at strengthening the management of asbestos risks across Great Britain.
The changes will introduce greater independence in asbestos clearance procedures, reinforce the importance of competent asbestos surveying and retain the existing Notifiable Non-Licensed Work (NNLW) category.
The regulatory amendment will come into force on 24 November 2026, with a 12-month transition period before enforcement begins in November 2027.

Strengthening Asbestos Safety
Although asbestos was banned in Great Britain in 1999, it remains present in many older buildings and continues to pose significant health risks when asbestos-containing materials are disturbed. The consultation considered three proposals intended to improve how asbestos risks are identified, assessed and controlled. Following consideration of the responses, HSE has confirmed its approach to each proposal.

1. Greater Independence in Asbestos Clearance
HSE will amend Regulation 20 of CAR 2012 to strengthen independence and impartiality in the four-stage clearance process undertaken following licensed asbestos removal work. The amendment will address potential conflicts of interest arising when a Licensed Asbestos Removal Contractor (LARC) appoints the analyst responsible for assessing whether an area is safe for reoccupation.
The changes are intended to provide greater confidence in the independence of clearance assessments and certification. HSE will also update its supporting guidance, including:

- Managing and Working with Asbestos (L143).
- Asbestos: The Analysts' Guide (HSG248).

Additional online guidance will help dutyholders understand how to appoint independent third-party service providers.

2. Improving the Quality of Asbestos Surveys
HSE has reaffirmed its strong recommendation that dutyholders use accredited organisations when commissioning asbestos surveys. Accurate and reliable surveys are essential for identifying asbestos-containing materials and informing effective risk management decisions. Rather than introducing additional regulatory requirements for surveys at this stage, HSE will develop further guidance and interventions to improve dutyholders' understanding of their responsibilities and the importance of commissioning competent survey providers.

3. Retaining Notifiable Non-Licensed Work
Following consultation, HSE has decided to retain the existing Notifiable Non-Licensed Work (NNLW) category. NNLW covers certain types of asbestos work that do not require a licence but are subject to additional regulatory requirements, including notification, medical surveillance and record-keeping. HSE will work with industry representatives to improve guidance and support the correct identification and management of work falling within this category.

Implementation and Timescales
The regulatory amendment will come into force on 24 November 2026. However, organisations will have a 12-month transition period to prepare for the new requirements, with HSE enforcement beginning in November 2027. HSE also plans to publish updated guidance during 2026 to support organisations in understanding and implementing the changes.
The regulator will continue to monitor and evaluate the effectiveness of the revised arrangements following implementation.

Additional Context
The changes follow recommendations made by the Work and Pensions Committee in its 2022 report examining HSE's approach to asbestos management.

Consultation responses highlighted several recurring concerns, particularly the competence of those involved in asbestos management, dutyholders' understanding of their legal responsibilities and the way specialist services are commissioned.

HSE intends to use this feedback to develop further guidance and interventions aimed at improving compliance and reducing asbestos exposure.

Key Learning Points

- Review asbestos management arrangements: Dutyholders should ensure their existing procedures remain effective and reflect current regulatory requirements.
- Ensure independent clearance assessments: Organisations commissioning licensed asbestos removal work should prepare for the strengthened requirements concerning the appointment of asbestos analysts.
- Use competent survey providers: HSE strongly recommends commissioning accredited organisations to undertake asbestos surveys.
- Understand asbestos work categories: Ensure work is correctly classified as licensed, notifiable non-licensed or non-licensed, with the appropriate controls applied.
- Keep up to date with guidance: Review forthcoming updates to HSE's Approved Code of Practice and supporting technical guidance.
- Prepare for implementation: Organisations affected by the changes should use the transition period to review their arrangements before enforcement begins in November 2027.



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Illegal Gas Work Put Householders at Risk

Summary

An illegal gas fitter has received a suspended prison sentence after carrying out dangerous and sub-standard gas work at five homes across the North East of England.
The individual continued undertaking gas work after he was no longer registered with the Gas Safe Register and advertised his services on social media and through flyers displaying the Gas Safe logo.

What Happened

Between June and September 2024, the gas fitter carried out work at homes in Blyth, Ryton, Hexham, Winlaton and Newcastle. The work included replacing boilers, installing gas pipework, working on boilers and gas fires, and disconnecting gas appliances. Although he had previously been registered, his Gas Safe registration had ended in February 2024. The work was found to be sub-standard and potentially dangerous. Incorrectly completed gas work can result in gas leaks, fires, explosions and carbon monoxide poisoning.

The Investigation

An investigation by the Health and Safety Executive (HSE) found that the individual had continued carrying out gas work despite no longer being registered to do so. He had also advertised his services on Facebook and distributed flyers displaying the Gas Safe logo, despite not being registered.

The Outcome

The gas fitter pleaded guilty to ten breaches of the Gas Safety (Installation and Use) Regulations 1998.
He was sentenced to eight months' imprisonment, suspended for two years. He was also ordered to complete a six-month mental health treatment requirement and 30 days of rehabilitation activity, and to pay £450 compensation and £200 towards prosecution costs.

Key Learning Points

- Gas work must only be undertaken by appropriately qualified and Gas Safe registered engineers.
- Previous registration does not authorise someone to undertake gas work once their registration has expired or ended.
- Poorly installed or maintained gas appliances and pipework can cause gas leaks, fires, explosions and carbon monoxide poisoning.
- Customers should ask to see an engineer's Gas Safe ID card and check their registration before allowing gas work to begin.
- Displaying the Gas Safe logo should not be relied upon as proof that an individual is currently registered.



The man used flyers with the Gas Safe logo on them – despite not being registered

More Information

Gas engineers and consumers can contact the Gas Safe Register in any of these ways:

- Gas Safe Register: gassaferegister.co.uk
- Phone – Consumers: 0800 408 5500; Engineers: 0800 408 5577
- Email – enquiries@gassaferegister.co.uk

Manufacturing Company Fined After Falling Pillar Drill Fractured Worker's Ribs

Summary

A manufacturing company has been fined £40,000 after an employee suffered serious injuries when a 500kg pillar drill fell during a lifting operation in Worcestershire. An investigation by the Health and Safety Executive (HSE) identified failures in risk assessment, planning and supervision of the lifting operation.

What Happened

The incident occurred in June 2024 at a manufacturing facility in Redditch, Worcestershire.

A 36-year-old employee was assisting with the movement of a newly purchased pillar drill using a forklift truck. During the lifting operation, the pillar drill, which weighed approximately 500kg, became unstable and fell, striking the employee. The employee sustained serious injuries, including fractures to twelve ribs.

The Investigation

The HSE investigation identified significant shortcomings in the company's arrangements for carrying out lifting operations.

Inspectors found that the company had failed to undertake a suitable and sufficient risk assessment for the lifting operation.

The company had also failed to ensure that the operation was:

- Properly planned by a competent person.
- Appropriately supervised.
- Carried out in a safe manner.

These failures exposed employees to the risk of serious injury from unstable or falling loads.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £40,000 and ordered to pay £5,032 in costs

Additional Context

The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) place specific duties on employers and those responsible for lifting equipment. Regulation 8 requires lifting operations to be properly planned by a competent person, appropriately supervised and carried out safely.

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

Forklift trucks must only be used for lifting operations for which they are suitable, with appropriate equipment and arrangements to ensure loads remain stable and secure.

Key Learning Points

- Undertake a suitable and sufficient risk assessment before carrying out lifting operations.
- Ensure lifting operations are properly planned by a competent person.
- Select lifting equipment that is suitable for the load and the intended operation.
- Assess the weight, dimensions, centre of gravity and stability of loads before lifting.
- Ensure loads are adequately secured and remain stable throughout the lifting operation.
- Provide appropriate supervision based on the complexity and risks of the operation.
- Keep employees clear of suspended or unstable loads and potential fall zones.
- Ensure employees involved in lifting operations have received appropriate information, instruction and training.

More Information

Safe Use of Lifting Equipment – Approved Code of Practice and Guidance (L113)
https://www.hse.gov.uk/pubns/books/l113.htm

The pillar drill involved in the incident



HSE

Pedestrian killed after being struck by bus at unsafe crossing

Summary

Transport for London (TfL) has been fined £2 million after a 74-year-old woman was struck and killed by a bus while using an authorised pedestrian crossing at a bus station. An investigation by the Health and Safety Executive (HSE) found that the crossing's unsafe layout, inadequate risk assessment and failures to monitor bus operations had exposed pedestrians to serious risks for several years.

What Happened

The woman was walking home after shopping when she attempted to cross a road at an authorised pedestrian crossing within the bus station.

She was approximately two-thirds of the way across when a double-decker bus turned a corner and struck her. She suffered fatal injuries and was pronounced dead at the scene.

The crossing, known as a 'red carpet' crossing, was intended to give pedestrians priority over vehicles. However, its position on a bend meant approaching bus drivers did not always have a clear view of pedestrians using it.

The Investigation

The HSE investigation identified significant failings in TfL's management of pedestrian and vehicle safety.

The crossing was positioned at the apex of a bend where buses entered the station. The layout and angle of approach meant drivers could turn towards the crossing without having a clear view of its entire length. Although pedestrians were intended to have priority, the crossing's design created ambiguity over who had the right of way, increasing the likelihood of a collision.

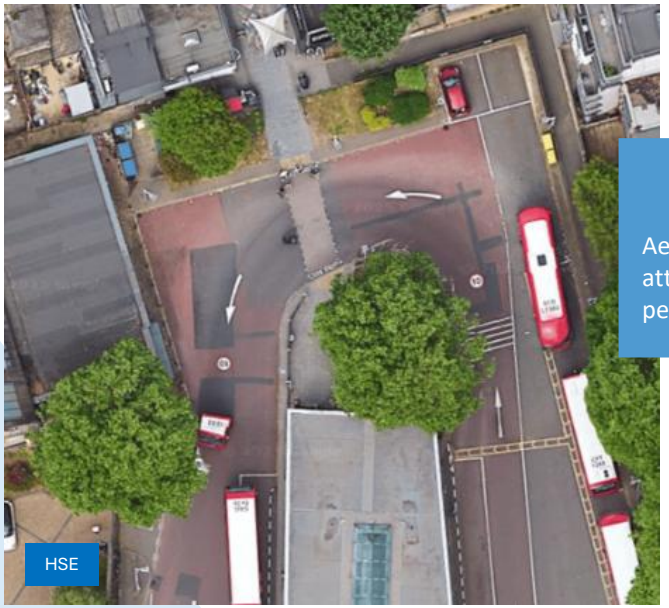
Investigators also established that:

- A pedestrian had been struck by a bus in similar circumstances in 2022, but TfL had failed to carry out a risk assessment of the crossing.
- CCTV footage recorded five near misses in the two days immediately preceding the fatal incident.
- TfL had failed to adequately monitor bus drivers operating within the station.
- The risks associated with the crossing's layout had remained inadequately controlled for several years.

The Outcome

TfL pleaded guilty to breaching Regulation 17(1) of the Workplace (Health, Safety and Welfare) Regulations 1992.

The organisation was fined £2 million and ordered to pay £5,081 in costs.



Aerial view of the crossing where the woman attempted to cross a road at an authorised pedestrian crossing within the bus station.

Key Learning Points

- Ensure pedestrian and vehicle routes are designed and maintained to allow safe movement throughout the workplace.
- Position pedestrian crossings where approaching drivers have clear and unobstructed visibility.
- Clearly establish and communicate pedestrian and vehicle priorities to avoid confusion over right of way.
- Carry out suitable and sufficient risk assessments of workplace transport arrangements, particularly where pedestrians and vehicles interact.
- Investigate accidents and near misses promptly, using the findings to identify hazards and improve existing controls.
- Review risk assessments following incidents, changes in circumstances or evidence that existing precautions may be inadequate.
- Monitor vehicle operations and driver behaviour to ensure safe working practices are consistently followed.
- Regularly review traffic management arrangements to ensure they remain effective and reflect actual operating conditions.

More Information

Workplace transport safety – HSE
https://www.hse.gov.uk/workplacetransport/

Workplace traffic routes – HSE
https://www.hse.gov.uk/workplacetransport/trafficroutes.htm

Worker Suffered Life-changing Hand Injuries After Becoming Trapped in Machinery

Summary

A paper products manufacturer was fined £80,000 after an experienced machine operator suffered life-changing hand injuries when her hand became trapped between moving rollers.

An investigation by the Health and Safety Executive (HSE) found that the company had failed to prevent access to dangerous parts of machinery, despite having previously received enforcement action relating to machinery guarding.

What Happened

The employee had worked as a machine operator for 11 years and was cleaning the rollers of a machine used to emboss designs onto tissue paper during napkin production. While carrying out the cleaning task, her right hand was drawn between the moving rollers, where it remained trapped for several minutes.

She sustained severe injuries, including the complete amputation of two fingers and partial amputation of two others.

The incident also left her with increased sensitivity in her dominant hand, significantly affecting her ability to perform everyday activities, including cooking, gardening, cycling and knitting.

The Investigation

The HSE investigation found that the machine was not fitted with an interlocked guard to prevent access to the moving print rollers.

As a result, employees could come into contact with dangerous moving parts while the machine was operating. Investigators also established that the company had previously been subject to enforcement action concerning machinery guarding during inspections in 2010, 2014, 2019 and 2021.

The absence of appropriate guarding meant that workers remained exposed to a foreseeable risk of serious injury.

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 £80,000 and ordered to pay £4,756 in prosecution costs.

Additional Context

PUWER requires employers to take effective measures to prevent access to dangerous parts of machinery or stop their movement before workers enter a danger zone. Fixed and interlocked guards are commonly used to prevent contact with hazardous moving components.

Cleaning, maintenance and adjustment activities can present particular risks where employees need access to machinery that would normally be guarded.

Employers must ensure that suitable procedures are established for these activities, including safe isolation where necessary.

Previous enforcement action should also prompt organisations to review whether similar risks exist elsewhere within their operations.

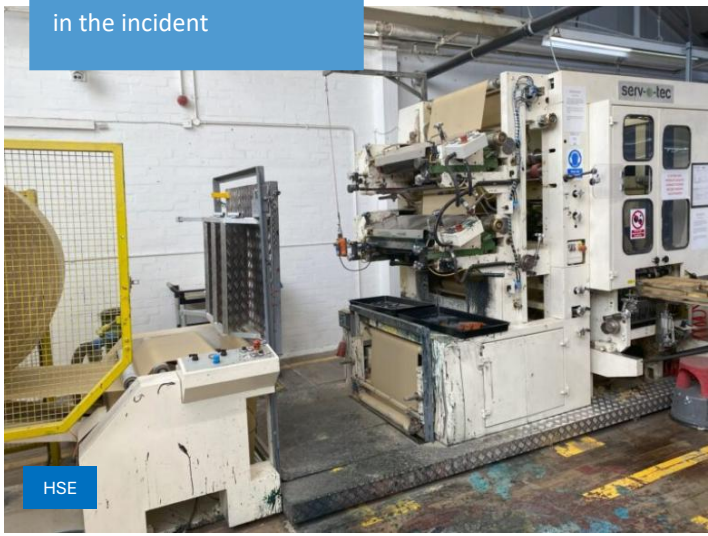
Key Learning Points

- Ensure dangerous moving parts of machinery are protected by suitable guards or other effective safeguards.
- Use fixed or interlocked guards where appropriate to prevent access to hazardous components.
- Establish safe procedures for cleaning, maintenance and adjustment activities.
- Ensure machinery is safely isolated before tasks that require access to dangerous moving parts.
- Regularly inspect and maintain machinery guards and safety devices.
- Review previous enforcement findings and ensure corrective actions are effective.
- Provide suitable information, instruction, training and supervision to machinery operators.

More Information

PUWER – HSE:
https://www.hse.gov.uk/work-equipment-machinery/puwer.htm

The machine involved in the incident



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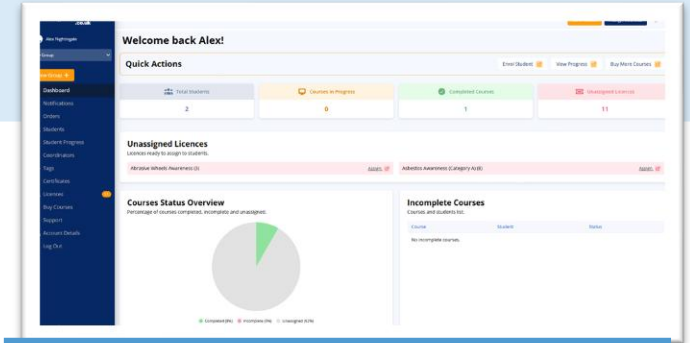
As the owners and operators of VitalSkills.co.uk, we've drawn on years of training experience and customer feedback to shape our next-generation learning platform. LMS-3 builds on the existing system, introducing new features and improvements to how our customers purchase, manage and complete their courses.



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



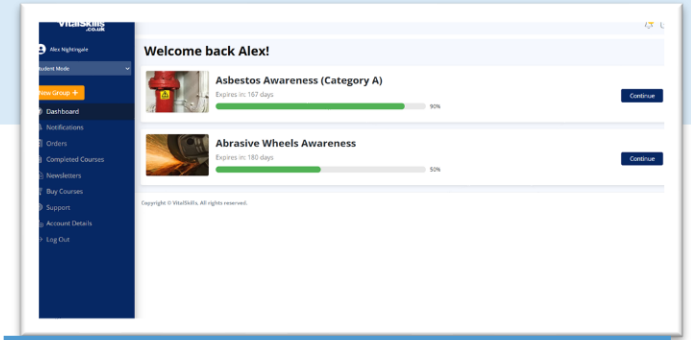
Preview of the new LMS-3 coordinator dashboard

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

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Preview of the new LMS-3 student learning experience

Worker Suffered Life-Changing Arm Injuries After Becoming Trapped in Food Processing Machine

Summary
A cold-pressed juice manufacturer has been fined £100,000 after an employee suffered life-changing injuries when his arm became trapped in a food processing machine. An investigation by the Health and Safety Executive (HSE) identified failures to prevent access to dangerous moving parts and adequately assess the risks associated with operating the equipment.

What Happened
The incident occurred at a food manufacturing facility in Corby, Northamptonshire, on 3 December 2024.

A 25-year-old employee was attempting to clear vegetable pulp from a machine known as a Mash Pump. After lifting the lid of the machine's hopper, he reached inside to remove the accumulated material.

The rotating worm screw caught his gloved hand, pulling his arm into the machinery and trapping it. The employee suffered multiple injuries, including fractures and lacerations, resulting in permanent, life-changing consequences.

The Investigation
The HSE investigation identified significant shortcomings in the management of machinery safety.

The manufacturer had failed to:
- Prevent access to dangerous rotating parts within the Mash Pump.
- Carry out a suitable and sufficient risk assessment of the hazards associated with operating the machine.
- Implement effective safeguards to protect employees from contact with moving machinery.

HSE guidance explains that employers must implement effective measures to prevent access to dangerous parts of machinery.

Fixed guarding will normally provide suitable protection. However, where routine access is necessary, interlocked guards, potentially incorporating guard locking, may be required to ensure dangerous moving parts stop before anyone can reach them.

The Outcome
The manufacturer pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998 (PUWER). The company was fined £100,000, ordered to pay £8,776 in prosecution costs.

Additional Context
Food processing machinery frequently incorporates rotating screws, conveyors, mixers and other moving components capable of causing serious injuries.

Tasks such as clearing blockages, cleaning and maintenance can expose employees to these hazards, particularly where machinery remains energised or guarding is inadequate. Under PUWER, employers must take effective measures to prevent access to dangerous parts of machinery or stop their movement before anyone enters a danger zone.

Risk assessments should consider both normal production activities and foreseeable interventions, including clearing blockages and removing accumulated material.

Key Learning Points
- Ensure all dangerous moving parts of machinery are adequately guarded to prevent access.
- Conduct suitable and sufficient risk assessments covering normal operations, cleaning, maintenance and foreseeable blockages.
- Use fixed guards wherever practicable and suitable interlocked guards where routine access is necessary.
- Ensure machinery is safely stopped and isolated before employees attempt to clear blockages or remove accumulated material.
- Provide employees with appropriate information, instruction and training on machinery hazards and safe operating procedures.
- Regularly inspect and maintain machinery guarding and associated safety devices to ensure they remain effective.
- Review risk assessments and safe working procedures whenever machinery, operating conditions or work activities change.

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

Machinery safety and guarding:
https://www.hse.gov.uk/work-equipment-machinery/

Food and drink manufacture – Health and safety:
https://www.hse.gov.uk/food/

Maintenance of work equipment:
https://www.hse.gov.uk/work-equipment-machinery/maintenance.htm

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Welding Sparks Caused Major Roof Fire and Endangered Four Workers

Summary

A plumbing contractor was fined £20,000 after welding operations caused a major fire on the roof of a 14-storey apartment building under construction. Four workers escaped the blaze through a single access opening and ladder. An investigation by the Health and Safety Executive (HSE) found serious failures in the planning, management and monitoring of hot work activities, including the absence of appropriate risk assessments and a permit to work.



The fire spread rapidly

What Happened

Four subcontractors were installing an air source heat pump on the roof of a residential building under construction. During the installation, sparks from welding activities ignited exposed rigid foam insulation that had been laid across the roof. The resulting fire spread rapidly across the roof area.

The workers were forced to escape through a single opening in the floor, using a ladder to reach the level below. There were no alternative escape routes from the roof, no suitable means of raising the alarm and no fire extinguishers available.

The fire continued to spread across the roof before eventually burning out when the available combustible material was consumed. Although the workers escaped without serious injury, the incident had the potential to result in multiple fatalities.

The Investigation

The HSE investigation found that the contractor had failed to adequately plan, manage and monitor the hot work activities. Despite having established company procedures requiring appropriate controls, these arrangements had not been followed.

Investigators identified several significant failings.

- No suitable risk assessment or method statement had been prepared for the welding activities.
- A hot work permit had not been issued.
- The presence of exposed combustible insulation had not been adequately controlled.
- Suitable fire prevention and emergency arrangements had not been established, leaving workers with only one means of escape.

The investigation concluded that the company had failed to implement effective measures to manage the foreseeable fire risks associated with welding on the roof.

The Outcome

The company pleaded guilty to breaching Regulation 15(2) of the Construction (Design and Management) Regulations 2015.

It was fined £20,000 and ordered to pay £8,270 in prosecution costs.

Additional Context

Hot work activities, including welding, cutting, grinding and other operations that generate heat or sparks, can create significant fire risks.

Key Learning Points

- Assess fire risks before undertaking welding, cutting, grinding or other hot work.
- Avoid hot work where safer alternative methods are reasonably practicable.
- Remove or adequately protect combustible materials before work begins.
- Implement and enforce suitable hot work permit procedures.
- Ensure risk assessments and method statements address the actual working conditions.
- Provide appropriate firefighting equipment and means of raising the alarm.
- Establish and maintain suitable emergency escape routes.
- Ensure workers understand emergency procedures before starting work.
- Monitor contractors and subcontractors to confirm that required safety arrangements are followed.
- Review fire precautions whenever construction activities or site conditions change.

More Information

Fire Safety in Construction, - HSE
https://www.hse.gov.uk/pubns/books/hsg168.htm

Trainee Scaffolder Died Following Five-metre Fall

Summary

A scaffolding company was fined after a trainee scaffolder died following a five-metre fall from a partially erected scaffold at a residential construction site.

An investigation by the Health and Safety Executive (HSE) identified significant failures in the management of work at height, including inadequate fall prevention measures and unsafe scaffolding practices.

What Happened

The trainee scaffolder was working with a colleague to erect scaffolding at the front of a two-storey property under construction.

During the work, he stood on an unsecured scaffolding board and fell approximately five metres.

Emergency services attended, but he died at the scene.

The Investigation

The HSE investigation found that the company had failed to ensure scaffolding work was undertaken safely and in accordance with recognised industry guidance.

Investigators identified several failings, including:
Failure to establish appropriate scaffolder safe zones.
Workers operating without suitable harnesses or lanyards.
Inadequate measures to prevent or mitigate falls.
Missing guardrails in areas where they were required.
Evidence that unsafe scaffolding practices had occurred previously.

The investigation established that the work being undertaken did not comply with recognised industry guidance for the safe erection of scaffolding.

The Outcome

The company pleaded guilty to breaching Regulation 4(1)(c) of the Work at Height Regulations 2005. It was fined £16,000 and ordered to pay £8,000 in prosecution costs and a £2,000 victim surcharge.

Additional Context

Falls from height remain a significant cause of serious workplace injuries and fatalities, particularly within the construction industry.

Scaffolding activities present particular risks during erection, alteration and dismantling, when permanent collective protection measures may not yet be fully installed. Industry guidance identifies the establishment of a scaffolder's safe zone, using collective fall protection measures, as the preferred method of preventing falls. Where collective protection is unavailable, appropriate personal fall protection equipment should be used.

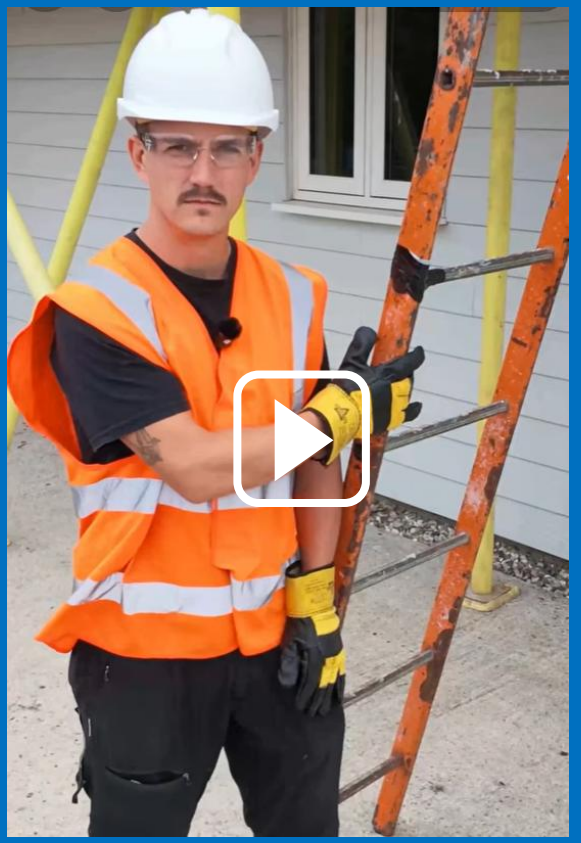
Key Learning Points

- Ensure scaffolding work is properly planned, organised and supervised.
- Follow recognised industry guidance for scaffolding erection, alteration and dismantling.
- Establish safe working zones using suitable collective fall protection measures.
- Provide and enforce the use of appropriate personal fall protection where required.
- Ensure scaffolding boards are correctly positioned and secured.
- Provide suitable training and supervision, particularly for trainees and inexperienced workers.
- Regularly inspect scaffolding activities to identify and correct unsafe practices.

More Information

See:
https://www.hse.gov.uk/construction/safetytopics/scaffoldinginfo.htm

Ladder safety on our social media



Timber Company Fined After Failing to Control Wood Dust and Lift Truck Risks

Summary

A timber processing company has been fined £20,000 after failing to protect employees from hazardous wood dust and risks associated with workplace lift trucks. The company failed to comply with three Improvement Notices issued by the Health and Safety Executive (HSE).

The company's managing director was also fined £5,000 and disqualified from acting as a company director for five years.

What Happened

The company, which supplies timber and manufactures gates, fencing panels and garden furniture, was found to have inadequate arrangements for controlling workplace health and safety risks.

HSE inspectors identified significant shortcomings in the management of wood dust exposure and the operation of rider-operated lift trucks.

Wood dust presents serious occupational health risks, including asthma, other respiratory conditions and cancer. Workers were not adequately protected from these hazards.

Inspectors also found that employees operating lift trucks had not received appropriate training, potentially placing themselves and others at risk of serious injury.

Despite being served with Improvement Notices requiring corrective action, the company failed to comply with the notices.

The Investigation

The HSE investigation identified several significant failings:

- Employees operating rider-operated lift trucks had not received appropriate training.
- Workers required to wear respiratory protective equipment (RPE) had not undergone suitable face fit testing.
- Suitable health surveillance arrangements were not in place for employees exposed to wood dust.
- The company had failed to comply with three Improvement Notices requiring improvements to workplace health and safety.

The investigation concluded that the company had failed to meet its duties under Section 2(1) of the Health and Safety at Work etc. Act 1974. The managing director was also found to have personally contravened the requirements of an Improvement Notice.

The Outcome

The company pleaded guilty to four offences, including breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and failing to comply with three Improvement Notices. The company was fined £20,000 and ordered to pay £5,000 in costs.

The managing director pleaded guilty to an offence involving failure to comply with an Improvement Notice and was fined £5,000, with an additional £2,500 in costs. He was also disqualified from acting as a company director for five years, following an application by the HSE under the Company Directors Disqualification Act 1986.

Additional Context

Wood dust is a significant occupational health hazard in woodworking and timber processing environments. Exposure to wood dust can cause occupational asthma and other respiratory conditions. Hardwood dust is also associated with an increased risk of nasal cancer. Employers must assess and control exposure to wood dust in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). This includes implementing suitable engineering controls, such as local exhaust ventilation, and providing appropriate respiratory protective equipment where necessary.

Where tight-fitting RPE is required, suitable face fit testing must be carried out to ensure an effective seal.

Key Learning Points

- HSE Improvement Notices are legally binding. Failure to comply with their requirements can result in prosecution, financial penalties and, where applicable, personal consequences for company directors.
- Assess the risks associated with wood dust exposure and implement effective control measures to protect employees from occupational illness.
- Use suitable dust extraction and other engineering controls to minimise airborne wood dust.
- Ensure employees using tight-fitting respiratory protective equipment undergo appropriate face fit testing.
- Provide suitable health surveillance for employees exposed to wood dust where required.
- Ensure rider-operated lift trucks are operated only by employees who have received appropriate training.
- Act promptly on enforcement notices and ensure that all required improvements are completed within the specified timescales.
- Recognise that directors and senior managers may face personal prosecution and disqualification where health and safety legislation is breached.

More Information

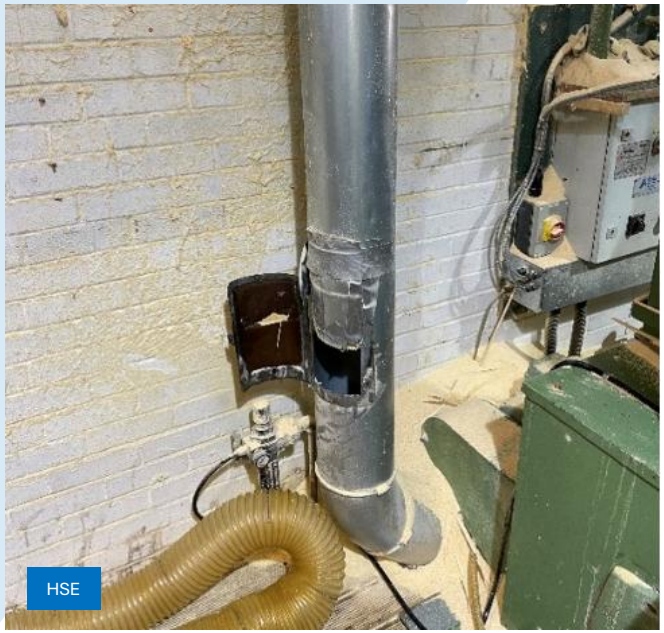
Wood dust – Health risks and controls:
https://www.hse.gov.uk/woodworking/wooddust.htm
Respiratory protective equipment – Fit testing:
https://www.hse.gov.uk/respiratory-protective-equipment/fit-testing-basics.htm
Health surveillance:
https://www.hse.gov.uk/health-surveillance/overview.htm

Woodworking Companies Fined £34,000 for Exposing Workers to Wood Dust and Other Safety Risks

Summary

Two woodworking companies in Cambridgeshire have been fined a total of £34,000 after employees were exposed to significant health and safety risks, including hazardous wood dust, excessive noise, dangerous machinery and workplace vehicles.

An inspection by the Health and Safety Executive (HSE) identified widespread failures in risk assessment, control measures and health and safety management.


HSE

What Happened

During inspections in July 2023, HSE inspectors identified numerous unsafe working conditions at two woodworking businesses.

Employees were exposed to hazardous wood dust and other substances because adequate control measures were not in place. Wood dust is a respiratory sensitiser that can cause serious long-term health problems, including occupational asthma.

Workers were also exposed to excessive noise without appropriate hearing protection. Many employees had not received suitable training in the use of personal protective equipment (PPE).

Other significant hazards included poorly managed workplace vehicle movements and machinery operating without adequate guarding or safety features.

The Investigation

The HSE investigation identified widespread deficiencies in the companies' health and safety management arrangements, including:

- Inadequate controls to prevent exposure to hazardous wood dust and other substances.
- Failure to undertake suitable risk assessments and workplace noise surveys.
- Insufficient PPE training and inadequate use of hearing protection.
- Poor management of workplace transport risks.
- Machinery and equipment being operated without appropriate guards or safety features.

Inspectors also identified a history of regulatory non-compliance. Since 2002, the two companies had received a combined total of 34 enforcement notices relating to health and safety breaches. Both businesses had previously been prosecuted for serious health and safety offences, including incidents resulting in significant employee injuries.

The Outcome

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

They received combined fines of £34,000 and were ordered to pay a total of £7,809.30 in costs.


HSE

Soldier Killed After Armoured Vehicle Turret Rotated During Training Exercise

Summary

A government department received a Crown Censure following the death of a 23-year-old soldier during a military training exercise.

An investigation by the Health and Safety Executive (HSE) found significant shortcomings in risk assessment, safe systems of work, instruction and training.

The incident occurred when the gun barrel of an armoured vehicle struck a tree, causing the turret to rotate unexpectedly and fatally injure the driver.

What Happened

The soldier was driving a tracked armoured reconnaissance vehicle during a military training exercise.

The exercise involved vehicles operating in a simulated combat environment.

While the vehicle was moving away from a simulated attack, its gun barrel, which extended beyond the side of the vehicle, struck a tree. The impact caused the turret to rotate rapidly.

A storage bin attached to the rear of the turret then struck the driver's head, causing fatal injuries.
The soldier died at the scene.

The Investigation

The HSE investigation found that there was no adequate safe system of work for driving the armoured vehicle during the exercise.

Risk assessments had failed to identify the danger posed to the driver by unexpected turret rotation. Consequently, suitable control measures had not been implemented to prevent the driver from being struck by equipment attached to the turret.

Investigators also found that risk assessments had not been properly reviewed following similar incidents in previous years. Training and instructions were inadequate, particularly concerning the risk of unintentional turret movement and the hazards associated with driving while the driver's head was exposed above the vehicle.

The Outcome

The government department accepted a Crown Censure for breaching Section 2(1) of the Health and Safety at Work etc. Act 1974.

A Crown Censure is the maximum sanction available to the HSE against a Crown body. It constitutes an official reprimand and creates a permanent public record of a failure to comply with health and safety law. No financial penalty is associated with a Crown Censure.

Additional Context

The Health and Safety at Work etc. Act 1974 applies to Crown bodies, including government departments. Although Crown bodies are subject to health and safety legislation, their legal status means that different enforcement arrangements apply.

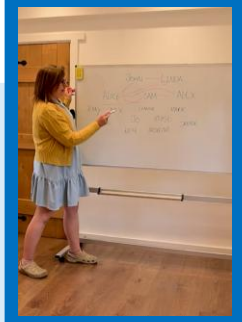
A Crown Censure provides a formal mechanism for holding such organisations accountable for serious failures.

The incident also highlights the importance of managing risks during training and simulation activities. Even where training must reflect challenging or hazardous operational conditions, employers remain responsible for identifying foreseeable risks and implementing reasonably practicable safeguards.

Key Learning Points

- Ensure training exercises are supported by suitable and sufficient risk assessments.
- Identify hazards arising from unexpected equipment movement or mechanical interaction.
- Establish safe systems of work for complex and potentially hazardous activities.
- Provide clear instructions and appropriate training before employees undertake high-risk tasks.
- Review risk assessments following incidents, near misses and changes in operating conditions.
- Ensure lessons from previous incidents are communicated and acted upon.
- Recognise that realistic training requirements do not remove the duty to manage foreseeable risks.
- Verify that risk controls remain effective during practical operations.

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Worker Suffered Life-Changing Injuries After Being Crushed by Reversing Truck

Summary

A vehicle recovery company was fined £28,000 after an employee suffered life-changing injuries when he was struck and crushed by a reversing recovery truck. An investigation by the Health and Safety Executive (HSE) found that the company had failed to implement a suitable workplace traffic management system or adequate precautions for reversing vehicles. The injured worker experienced serious physical injuries and lasting restrictions on his mobility and independence.

What Happened

The employee was carrying out routine duties in a vehicle recovery yard when he was struck by a reversing recovery truck. The vehicle knocked him down and crushed him, causing extensive injuries.

He suffered fractures to both legs and an arm, a punctured lung and a fractured rib. He was taken to hospital, where he remained for five weeks and underwent several operations, including reconstructive surgery and skin grafts.

More than ten months after the incident, the worker remained unable to return to work.

His injuries left him dependent on walking aids, including crutches, a walking frame and a wheelchair.

He also required regular assistance with everyday activities and faced the prospect of permanent mobility restrictions. The incident had a significant impact on his independence, family life and wellbeing.

Key Learning Points

- Carry out suitable risk assessments for workplace vehicle movements.
- Separate pedestrians and moving vehicles wherever reasonably practicable.
- Introduce one-way traffic systems to eliminate unnecessary reversing.
- Provide clearly marked pedestrian walkways and designated crossing points.
- Establish safe arrangements for vehicle reversing and manoeuvring.
- Consider suitable barriers, reversing cameras, mirrors and warning alarms.
- Ensure drivers and vehicle marshals receive appropriate training.
- Maintain adequate visibility and lighting within vehicle operating areas.
- Regularly inspect and review workplace traffic management arrangements.
- Investigate near misses and take action to prevent future incidents.

The Investigation

The HSE investigation found that the company had failed to establish suitable arrangements for managing vehicle movements within its premises. There was no adequate workplace traffic management system to ensure that pedestrians and vehicles could circulate safely. The company had also failed to implement sufficient precautions to assist drivers when reversing.
These shortcomings exposed employees working on foot to the risk of being struck by moving vehicles. The investigation concluded that suitable traffic management arrangements could have prevented the incident.

The Outcome

The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £28,000 and ordered to pay £2,000 in prosecution costs.

More Information

Workplace Transport – HSE:
https://www.hse.gov.uk/workplacetransport/index.htm

Images of the site before, and after, HSE intervention



Two Companies Fined £1.3 Million After Falling Window Killed Pedestrian

Summary

Two companies have been fined a combined £1.3 million after a 130kg window fell approximately 300 feet from the 26th floor of a luxury residential development in London, killing a pedestrian below. An investigation by the Health and Safety Executive (HSE) identified serious failures in the design and risk assessment of the bespoke windows, alongside missed opportunities to address safety concerns following an earlier near miss.

What Happened

A coach driver was returning to his vehicle when a window fell from the 26th floor of a residential development. The window struck him, causing fatal injuries. The development comprised three luxury residential towers featuring bespoke curved penthouse windows.

During the design process, the windows had been changed from opening inwards to opening outwards. This introduced a significant risk that a detached window could fall onto the public pedestrian area below. Despite this change, the associated risks were not adequately assessed or controlled.

The Investigation

The HSE investigation identified significant shortcomings in the design, assessment and management of the window installation.

The safety of the outward-opening windows depended on a single restrictor secured by one screw. The manufacturers had not confirmed that the fittings were suitable for the bespoke curved windows. Investigators also discovered that a similar window had fallen from the penthouse level during construction in August 2017, narrowly missing two workers.

Although the principal contractor conducted an internal review following this near miss, important safety concerns were not effectively addressed. Following the fatal incident, the windows were redesigned to open inwards, eliminating the risk of an open window detaching and falling onto pedestrians below.

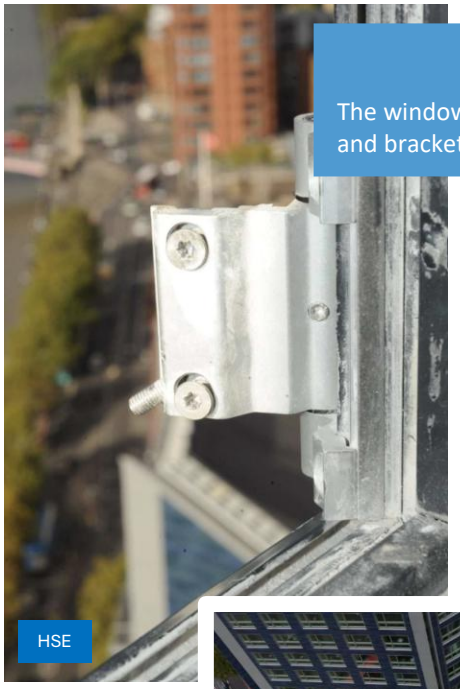
The Outcome

Both companies were found guilty of breaching Section 3(1) of the Health and Safety at Work etc. Act 1974, which requires employers to conduct their undertakings in a way that does not expose people who are not employees to risks to their health and safety, so far as is reasonably practicable. The penalties imposed were:

- Principal contractor and developer: Fined £1 million and ordered to pay £125,000 in costs.
- Specialist window designer: Fined £300,000 and ordered to pay £125,000 in costs.

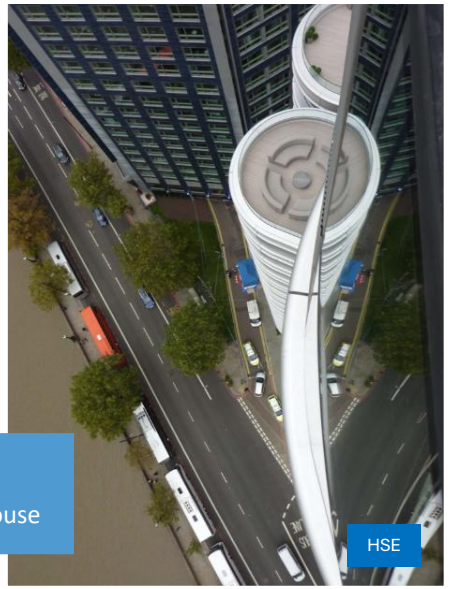
Key Learning Points

- Identify and eliminate foreseeable hazards during the design stage wherever reasonably practicable.
- Assess the safety implications of design changes before they are approved and implemented.
- Ensure that components and fittings are suitable for their intended application, particularly where bespoke designs are involved.
- Avoid relying on single components where their failure could result in serious injury or death.
- Consider risks to members of the public as well as workers during design, construction and occupation.
- Investigate near misses thoroughly and ensure that identified corrective actions are implemented and verified.
- Establish clear responsibilities and effective communication between developers, principal designers, contractors and specialist designers.
- Review existing safety arrangements when incidents or new information indicate that controls may be inadequate.



The window frame and bracket

HSE



Height of penthouse

HSE

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.



Sexual Harassment Awareness

Core information that everyone needs 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
- Multi-User Discounts: £12+VAT to £6.50+VAT

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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
- Multi-User Discounts: £12+VAT to £6.50+VAT

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IOSH Safety Health & Environment for Construction Site Managers
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IOSH-Approved Online Course Bundles

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+ 5 IATP, RoSPA, IoH, CPD Assured Courses
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+ IOSH Managing Sustainably
+ 5 IATP, RoSPA, IoH, CPD Assured Courses
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Asbestos Awareness (IATP)
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Asbestos Awareness for Architects and Designers
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Asbestos Awareness for Architects and Designers (IATP)
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Health, Safety and Welfare Awareness for Workers
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