

Company fined after machine operator suffered serious leg injury

A titanium supplier has been fined after an employee sustained multiple fractures to his leg whilst operating a metal cutting band saw machine.

Kidderminster Magistrates' Court heard that on 20 September 2017, Steven McDonald, a VSMP0 Tirus Limited employee, was seriously injured by a falling titanium plate at The IO Centre in Nash Road, Redditch. Almost 1.5 tonnes of titanium plate fell from the bed of a metal cutting band saw machine trapping his leg underneath. The sheets being cut were significantly larger than the machine bed.

An investigation by the Health and Safety Executive (HSE) found the company had failed to suitably and sufficiently assess the risk of material falling from the machine bed and failed to put in measures to control the risk. An extension to the machine bed or stanchions with back stops would have prevented the material from falling from the machine bed.

VSMP0 Tirus Limited of Nash Road, Redditch, Worcestershire pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. They were fined £200,000 and ordered to pay costs of £7,293.15.

Steven McDonald said: "This has been the worst couple of years of my life. I feel I have been dealt a bad hand. I have come through it, but I have a long way to go. My recovery isn't going to be a quick fix and I think everyone knows this. My friends, family and the company have supported me."

HSE inspector Elizabeth Thomas added: "A simple, cost-effective solution could have prevented this horrendous injury."

Notes to Editors:

1. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. We prevent work-related death, injury and ill health through regulatory actions that range from influencing behaviours across whole industry sectors through to targeted interventions on individual businesses. These activities are supported by globally recognised scientific expertise. www.hse.gov.uk

2. More about the legislation referred to in this case can be found at:

www.legislation.gov.uk/

3. General guidance of engineering workshops can be found at:

www.hse.gov.uk/pUbns/priced/hsg129.pdf

4. HSE news releases are available at <http://press.hse.gov.uk>

The post [Company fined after machine operator suffered serious leg injury](#) appeared first on [HSE Media Centre](#).

[HSE to prosecute following Birmingham fatal wall collapse in 2016](#)

A Health and Safety Executive (HSE) prosecution is being brought against two companies after five workers were fatally injured and another seriously injured at a site in Birmingham.

On 7 July 2016, Ousmane Kaba Diaby, Saibo Sumbundu Sillah, Bangally Tunkara Dukuray, Almamo Kinteh Jammeh and Mahamadou Jagana Jagana were all fatally crushed by a collapsing wall at the site on Aston Church Road in Nechells area of the city. Tombong Camara Conteh sustained serious injuries.

A joint investigation by HSE and West Midlands Police has taken place.

Ensko 10101 Limited (previously known as Shredmet Ltd) of Riverside Works Trevor Street, Nechells, Birmingham will face charges under Sections 2(1) and 3(1) of the Health and Safety at Work Act 1974.

Hawkeswood Metal Recycling Limited of Riverside Works Trevor Street, Nechells, Birmingham, will face charges under Sections 2(1) and 3(1) of the Health and Safety at Work Act 1974.

A prosecution has also been approved against two individuals.

The first court hearing is yet to be confirmed.

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4. Primacy was handed to HSE in December 2017, and the inquest into the five deaths took place in November 2018 where an outcome of accidental death was recorded. Please refer to HM Coroner for further detail on these coronial proceedings.
5. We will issue a separate note once a hearing date and location has been confirmed.

The post [HSE to prosecute following Birmingham fatal wall collapse in 2016](#) appeared first on [HSE Media Centre](#).

[Engineering company sentenced after apprentice narrowly escapes serious injury](#)

A plant hire company has been fined after an apprentice avoided a potentially fatal crush injury from a mobile crane.

During proceedings at Knights Chamber, Nightingale Court, in Peterborough it was heard that on 3 August 2016, an apprentice at M&J Engineers Limited had climbed on to the roof of an accommodation cabin to attach a power float to the chains of a mobile crane. The crane operator, who had not been appropriately trained, began to extend the boom and move the crane into position. The crane had not been set up correctly and the boom of the crane toppled over toward the apprentice. The apprentice jumped out of the way of the boom avoiding a potentially fatal incident. However, his fall from height caused injuries to his leg and back.

An investigation by the Health and Safety Executive (HSE) found the company did not have a safe system of work in place and the crane operator had not been adequately trained. There was no clear instruction concerning the use of the crane or which areas the crane was prohibited from operating. They also had no way of ensuring that the apprentice was suitably managed.

M&J Engineers of Cashel Works, Cadwell Lane, Hitchin, Hertfordshire was found guilty of breaching Section 2(1) Health and safety at Work etc Act 1974. They were fined £220,000 and ordered to pay costs of £65,443.72.

Speaking after the hearing, HSE inspector Nigel Fitzhugh said: “Those in control of work have a responsibility to provide adequate training to their employees so that they can operate equipment safely and devise safe methods of working. This includes providing the appropriate information, instruction and training to their workers.”

Further information about managing health and safety is available here:

<http://www.hse.gov.uk/managing/index.htm>

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The post [Engineering company sentenced after apprentice narrowly escapes serious injury](#) appeared first on [HSE Media Centre](#).

[Engineering firm sentenced after employee suffers permanent nerve damage](#)

An engineering company has been fined after a worker was diagnosed with hand-arm vibration syndrome (HAVS).

Manchester Magistrates’ Court heard that prior to 22 October 2018, an overall lack of management relating to the use of vibrating tools at AIM Engineering Ltd led to an employee being diagnosed with HAVS. Regular use of vibrating tools causes the painful and disabling disorder which, in this case, has left the employee with irreparable nerve damage to the hands and arms.

An investigation by the Health and Safety Executive (HSE) found that AIM Engineering Ltd of Wythenshaw, Manchester did not monitor how much work the employees were doing with vibrating tools. In addition, the company did not have any health surveillance in place, which would have picked up early signs of the disease. In 2017 an external company made recommendations to reduce employees' exposure to vibration when working with vibrating tools, and to implement health surveillance. This resulted in an employee being diagnosed with HAVS.

AIM Engineering Ltd of Southmoor Industrial Estate, Southmoor Road, Manchester pleaded guilty to breaching of Regulation 2 (1) of the Health and Safety at Work Act etc. 1974 and was fined £300,000 with costs of £7,831.90.

Speaking after the hearing, HSE inspector Jennifer French said: "This was a case of the company completely failing to grasp the importance of controlling employees' exposure to vibration. Had appropriate controls been in place to reduce the amount of vibration workers were exposed to, and appropriate health surveillance put in place, the employee's condition would not have been allowed to develop to a severe and life altering stage."

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Her Majesty's Prison & Probation Service accepts Crown Censure after prison officers sustain serious burns in training exercise

Her Majesty's Prison & Probation Service (HMPPS) has been issued with a Crown Censure by the Health and Safety Executive (HSE) after nine prison officers suffered burns in a training exercise.

On 28 June 2018, the prison officers were taking part in a petrol bomb training exercise as part of an eight-day commanders' course at The National Tactical Response Group (NTRG) training facility when the incident occurred. On completion of the course officers would be qualified to play an important leadership role should a prison disorder take place.

It was an extremely hot day with temperatures in excess of 30 degrees and no breeze. The staff had set up a water fountain near to the exercise space where officers could cool off whilst wearing their protective kit.

Each of the trainee commanders had already completed the petrol bomb activity twice while leading serials of six prison officers, using their shields for protection, navigating a petrol bomb at their feet and a second petrol bomb to the side without any issues.

After those exercises were complete the trainee commanders were told to form into a serial of 18 in three rows of six and were petrol bombed as a group; witness reports state that between four and 10 petrol bombs were thrown. The officers became engulfed in flames, which burnt through their protective clothing, forcing them to break ranks to try and extinguish the flames underneath the water fountain.

The officers suffered burns to their bodies, varying in severity from minor burns and scalds to third degree burns.

"My clothes were burning, my helmet bubbled up and my body armour was charred", said one of the officers. "One of the petrol bombs hit me on the head and I was overcome with fire, the flames were 12 feet easily, I was really scared as it got hotter and hotter," said another.

An investigation by HSE found that HMPPS did not call an ambulance to the scene and officers were taken to hospital in a minibus. HMPPS failed to report the injuries to HSE until four months after the incident.

The investigation also found that the practice of petrol bombing the whole group of trainee commanders was not part of the official training and there was no requirement for it in any documentation or training manual. The prison officers interviewed had almost 270 years of service between them and had never been petrol bombed in any live disorder incident.

There was a failure to provide adequate risk assessments for the handling of petrol and the exercise itself. The person making the petrol bombs for the exercise had no recall of being trained in the handling of petrol or having any instruction in how much petrol each bomb should contain; and had created a maximum of 48 petrol bombs consisting of two thirds of a pint of petrol in each milk bottle.

The incident has had long term consequences with some of the officers involved reporting that they continue to suffer from their physical injuries and others from symptoms of post-traumatic stress disorder (PTSD).

Carol Downes MBE, an HSE inspector on HSE's Defence and Public Protection Team, said: "HMPPS was using practical training to prepare officers to deal with high risk situations of serious disorder in prison establishments. We accept that this type of training comes with an additional level of risk, but this does not mean that the risks during that training should be uncontrolled.

"HMPPS, like any other employer, has a duty to make sure that where work or training is to be done that causes danger, that danger or risk is controlled as far as they reasonably can. Unfortunately, on this day those risks were not adequately controlled resulting in nine prison officers suffering burn injuries."

By accepting the Crown Censure, HMPPS has acknowledged that but for crown immunity, there was sufficient evidence to provide a realistic prospect of conviction for breaching Section 2(1) & Section 3(1) of the Health and Safety at Work etc. Act 1974.

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2. HSE news releases are available at <http://press.hse.gov.uk>
3. As a Government body, Her Majesty's Prison and Probation Service (HMPPS) cannot face prosecution in the same way as private or commercial organisations this is known as Crown Immunity.
4. Section 2(1) of the Health and Safety at Work etc. Act 1974, states that: "It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees".
5. There is no financial penalty associated with a Crown Censure.
6. More information on Crown Censures can be found here:
<http://www.hse.gov.uk/enforce/enforcementguide/investigation/approving-enforcement.htm> [1]
7. The Code for Crown Prosecutors [2] sets out the principles for prosecutors to follow when they make enforcement decisions. HSE's approach to Crown Censure is set out in its enforcement policy statement[3].

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