

Company fined after worker became entangled on a manual lathe

An engineering company, has been fined for safety breaches after an employee suffered serious injuries to his left arm and hand whilst operating a manual lathe.

Sheffield Magistrates' Court heard that, on 26 February 2018, a 61-year-old worker of Wincobank Fabrication and Engineering Ltd (WFE) was polishing a solid chrome bar on the lathe using hand-held emery cloth when his left hand and arm became entangled with the rotating bar on the company site on Sheffield Road, Rotherham. As a result, his left index and middle fingers were amputated and his wrist and two bones in his left forearm were broken. The worker required surgery and metal plates were inserted into his arm.



An investigation by the Health and Safety Executive (HSE) found that the hand application of emery cloth on manual lathes was custom and practice amongst lathe operators at WFE. The risk assessment in place for the machine had not considered the risks from polishing, or identified suitable control measures for operation of the lathe. At the time of the incident, the injured party had been employed at WFE for just under one month and had not received adequate instruction and training on how to polish safely. The investigation also found that he was wearing gloves at the time of the incident which significantly increases the risk of entanglement. HSE guidance clearly states that hand polishing on a manual lathe with emery cloth is strictly prohibited.

Wincobank Fabrication and Engineering Ltd of The Ickles, Sheffield Road Rotherham pleaded guilty to breaching Section 2 (1) of the Health & Safety at Work etc Act 1974. The company has been fined £33,500 and ordered to pay costs of £1,426.

After the hearing, HSE inspector Lois Taylor commented: "Serious accidents

involving the use of emery cloth on metalworking lathes occur every year.

“Such accidents could easily be avoided by properly assessing the risks to determine whether the use of emery cloth on these machines can be eliminated completely. Where this is not practicable, then a safe method should be used for its application.

This incident could so easily have been avoided by simply carrying out correct control measures and safe working practices”

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^[1]
2. More about the legislation referred to in this case can be found at: www.legislation.gov.uk/ ^[2]Please see the link below to the page on HSE’s website that is the best guide to doing it the right way:
3. www.hse.gov.uk/pubns/eis2.pdf
4. HSE news releases are available at <http://press.hse.gov.uk>^[3]

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