

Foundry sentenced after worker suffers life-changing burns

A foundry has been sentenced for safety breaches after an employee suffered life-changing burns following an eruption of molten slag during a slag tipping procedure.

Telford Magistrates' Court heard how on 21 February 2020, the slag was being poured into a container at Goodwin Steel Castings in Stoke-on-Trent. The container had been incorrectly stored outside during a period of stormy weather. Water accumulated in the container, though it was not visible to the naked eye. When the molten slag was poured into the container, it reacted with the water causing a violent eruption.

The employee, sustained burns to a third of his body including his face, neck, stomach, arms, legs and feet, which required multiple skin grafts.

An investigation by the health and Safety Executive (HSE) found the management of the slag containers was inadequate. They were regularly stored incorrectly outside with the open face up, allowing water ingress. The measures in place to inspect and ensure they were free from water contamination before use were also not adequate.

Goodwin Steel Castings Ltd of Ivy House Road, Hanley, Stoke-on-Trent pleaded guilty to breaching Section 2(1) of the Health and Safety at Work Act 1974. They were fined £133,000 and ordered to pay costs of £5,226.30

Speaking after the hearing, HSE inspector Alex Nayar said: "This injury could easily have been prevented – the risk should have been identified and controls implemented.

"Relevant industry sectors are reminded of the need to ensure that all material and equipment likely to make contact with molten material is free from water contamination as far as they possibly can."

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. hse.gov.uk
2. More about the legislation referred to in this case can be found at: legislation.gov.uk/
3. HSE news releases are available at <http://press.hse.gov.uk>

4. Further information about gas safety can be found at <http://www.hse.gov.uk/gas/>

[Company prosecuted after worker loses hand in lathe](#)

A UK manufacturer of brick products, Ibstock Brick Ltd, has been fined for safety breaches after a worker's hand was entangled and wrapped around the rotating shaft on a lathe.

North Staffordshire Justice Centre heard how, on 28 February 2020, a maintenance engineer was in the process of polishing a metal shaft as it rotated in a manual lathe, using an emery cloth directly by hand and whilst wearing gloves. The emery cloth became entangled around the rotating shaft and dragged the engineer into the lathe resulting in his hand being severed in the machine. The engineer subsequently underwent surgical amputation below the elbow.

An investigation by the Health and Safety Executive (HSE) found that there were failures in the arrangements and controls for the task performed. The risk assessment in place was not suitable and sufficient in that it did not properly assess or address entanglement risk associated with the direct manual application of emery cloth to the workpiece or the use of gloves. There was inadequate training, instructions and supervision to ensure that the risks from entanglement with gloves or the emery cloth were prevented.

Ibstock Brick Ltd of Audley Road, Newcastle under Lyme pleaded guilty to breaching Section 2(1) of the Health and Safety Act 1974 and have been fined £530,000 and ordered to pay costs of £4,548.20

After the hearing, HSE inspector Marie-Louise Riley-Roberts said: "Those in control of work have a responsibility to assess risk and devise safe methods of working in which their employees should then be instructed and trained. If Ibstock Brick Ltd had, had effective managerial arrangements in place for the task undertaken and ensured their employees were following a safe system of work, based upon risk assessment, safe systems of work, supervision, information, instruction and training, then the life changing injuries sustained by this worker could have been prevented.

Companies should be aware that HSE will not hesitate to take appropriate enforcement action against those that fall below the required standards".

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2. More about the legislation referred to in this case can be found at: legislation.gov.uk/
3. HSE news releases are available at <http://press.hse.gov.uk>
4. Guidance on the use of emery cloth is available at [EIS2: The use of emery cloth on metalworking lathes \(hse.gov.uk\)](http://EIS2:The%20use%20of%20emery%20cloth%20on%20metalworking%20lathes%20(hse.gov.uk))

[Company and care home owner admit criminal liability after care home resident dies following lift fall](#)

A lift maintenance company has been sentenced and a care home owner cautioned after a resident and care worker plunged four metres to the basement in a faulty lift at a residential care home.

Damage to the lift had been reported only a week before the incident, which resulted in the death of 85-year-old Kenneth Bardsley. The care worker sustained minor injuries to her mouth, face and left eye.

Manchester Minshull Street Crown Court heard that on 30 January 2017, the employee of the care home on Greenfield Avenue, Manchester entered the lift on the first floor to transport Mr Bardsley to the ground floor dining room. The lift began to descend, but stopped after a few seconds as the corner of a damaged door caught on the lintel plate of the ground floor landing entrance causing it to bend. The lift was held for a few moments until the weight of the lift and its occupants caused the lift door to buckle, which in turn allowed the lift to drop four metres uncontrolled to the basement.

An investigation by the Health and Safety Executive (HSE) found that damage to the left-hand door of the lift had been reported to Lancs and Cumbria Lifts UK Ltd, responsible for the maintenance of the lift, on 23 January 2017. Engineers had attended on the same day to deal with the problem and

found that a part was required to complete repairs, but by the time of the incident no repair had taken place.

In the interim, Lancs and Cumbria Lifts UK Ltd attended the care home on the day of the incident for a planned quarterly maintenance visit, but did not follow up on repairing the door and the lift remained in use. An HSE investigation found that mechanical repairs had not been carried out in accordance with good engineering practice and maintenance was of a poor standard.

The care home was owned by Premum Care Ltd, but trading as Serendipity Care Home. It was managed by its sole director Tabinda Dahir who despite being fully aware of ongoing issues with the lift did not ensure that there was a system in place to deal with reports of defects and that action was taken in response to issues identified.

Whilst thorough examination reports had been carried out every six months, as required by law, these had not been provided by Premum Care to Lancs and Cumbria Lifts UK Ltd nor requested by the lift maintenance company to inform maintenance work, despite it being a contractual obligation for them to be provided with the reports.

Lancs and Cumbria Lifts UK Ltd of Douglas Bank House, Wigan Lane, Wigan Manchester pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. It was accepted that its failings had not been causative of the lift falling on the 30 January 2017. The company was fined £14,400 and ordered to pay £45,000 in costs.

Premum Care Ltd, of Greenfield Avenue, Urmston, Manchester went into liquidation shortly after the criminal prosecution began.

Speaking after the hearing, HSE inspector Jennifer French said: "This sad case involving a vulnerable resident and a care worker highlights the importance of good communication.

"If Lancs and Cumbria Lifts UK Ltd had been in receipt of the reports, which identified repeated faults, further opportunity would have been afforded to carry out the necessary repairs earlier and prevent this tragic incident occurring.

"Where several parties are responsible for the management of risk an effective system should be place to deal with reports of defects when they are identified."

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2. More about the legislation referred to in this case can be found at:
<https://www.hse.gov.uk/work-equipment-machinery/loler.htm>
<https://www.hse.gov.uk/legislation/hswa.htm>

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

[Sawmill fined after worker's finger is severed in machinery](#)

A sawmill has been fined after a worker injured his finger when his hand came into contact with the moving parts of a machine.

Plymouth Magistrates' court heard how, on 20 March 2018, an employee of Truro Sawmills was examining the moving parts at the rear of a saw to check why it had been cutting inaccurately. The saw remained in operation while he did so, and his glove became caught in the moving parts causing him to sever his index finger on his left hand.

An investigation by the Health & Safety Executive (HSE) found the company failed to ensure that access to a cross-cut saw's dangerous moving parts was prevented by the use of a guard, and failed to deliver adequate training to their employees.

Truro Sawmills of Pendale, Penhallow, Truro, Cornwall pleaded guilty of breaching Regulation 11 (1) of the Provision and Use of Work Equipment Regulations 1998 (PUWER) and Section 2 (1) of the Health & Safety at Work Act 1974. The company was fined £40,000 and ordered to pay costs of £15,594.

Speaking after the hearing, HSE inspector Melissa Lai-Hung said: "This injury was easily preventable. Employers should make sure they properly assess and apply effective control measures to minimise the risk from dangerous parts of machinery.

"Those in control have a responsibility to devise safe methods of working and to provide the necessary information, instruction and training to their workers."

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

www.legislation.gov.uk/

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

[HSE calls on designers to prepare now for upcoming regulatory changes to building safety](#)

As part of work underway to establish a new Building Safety Regulator and reform the building safety system, HSE is urging those who design high-rise buildings to act now to prepare for the changes coming when the Building Safety Bill becomes law.

The Building Safety Bill, currently making its way through Parliament, aims to implement all of the recommendations set out in Dame Judith Hackitt's "Building a Safer Future" report, and in places goes further. The reforms include a more stringent approach to the design and construction of high-rise buildings, clearer responsibilities on designers to ensure these buildings are safe, and new measures so that everyone doing design or building work is competent to carry out that work in line with building regulations.

People working on the design of a high-rise building, from the development of a planning application through to building regulations approval will need to understand the building's intended use, correctly identify the risks, and own and manage those risks to determine the safety of a building.

There will be a requirement to record and provide evidence of decision-making during the design process, and a need to be engaged throughout a building project to handover to the end client. Prepare now for these changes.

Peter Baker, Chief Inspector of Buildings at the Health and Safety Executive, said:

"Designers have a strong influence on safety and standards, particularly during the very early planning and design stages of a building project. Their decisions not only affect the safety of those carrying out the building work, but also those maintaining, using, or living in a building after it is built.

"I encourage designers to act now and prepare for the more stringent regulatory regime. HSE will continue to work with the building design industry and related businesses to support them to deliver safe and high-performing buildings and ensure that residents of high-rise buildings are

safe, and feel safe, in their homes now and in the future.”

Colin Blatchford, Operational Policy Lead for Gateways and Building Control at HSE, said:

“Everyone involved in the design of high-rise buildings must take a proactive approach to managing building safety from the earliest stages of the design process. These changes are coming. Those involved need to plan ahead through correctly identifying, taking ownership and managing the risks – ensuring key decisions are recorded throughout the process.

“Once the Building Safety Bill becomes law, there will be a requirement for a safety case report when a building is completed and occupied. It is important to consider this at the early design stage for your clients and future residents’ safety.

“Building safety changes are coming and will affect everyone involved in a high-rise building project beyond its design. We urge that you act now.”

Notes to Editors

1. The creation of the Building Safety Regulator (BSR) is a key component of the Government’s reforms of the building safety system following the Grenfell Tower tragedy and the recommendations in Dame Judith Hackitt’s report of her independent review into building regulation and fire safety.
2. The BSR and its functions from part of the draft Building Safety Bill published in July 2020 to implement the biggest change to building safety for 40 years. HSE is leading the work to design, develop and deliver the BSR functions on behalf of Government and is recruiting across a wide range of roles and expertise to make sure the new building safety regime is fit-for-purpose. It is working with industry, the Department for Levelling Up, Housing and Communities, Home Office, local authorities, fire and rescue services, residents and other stakeholders to pave the way for the fully-fledged regulator.
3. 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. [hse.gov.uk](https://www.hse.gov.uk)
4. HSE already has a role in relation to specific aspects of building safety. HSE regulates workplace health and safety in the high-risk construction industry, the natural gas supply industry, the safety of domestic gas installations, and work with asbestos in buildings.
5. For the [Building Safety Bill](https://www.parliament.uk) visit [parliament.uk](https://www.parliament.uk)
6. For the [Independent Review of Building Regulations and Fire Safety](https://www.gov.uk) Building a Safer Future report, visit [gov.uk](https://www.gov.uk)
7. HSE is an Executive Non-Departmental Public Body sponsored by the Department for Work and Pensions (DWP). Further information about HSE and

its Board can be found

at: <https://www.hse.gov.uk/aboutus/hseboard/board.htm>