

# Fabrication company and director in court after worker injures finger in machinery

A handrail manufacturing company has been fined after an employee's hand was drawn into a roller and crushed.

Manchester Magistrates' Court heard how, on the 27 March 2019, an employee of Dealercast Ltd in Hardy Street, Eccles was being trained by company director Chris Ellor to use a rolling machine to bend pieces of steel tube. While the employee was feeding the tubing between the rollers of the machine, the heavy-duty gloves he was wearing caught between the tubing and one of the rollers. His hand was drawn into the machine injuring his little finger, which later had to be amputated from the second knuckle.

An investigation by the Health and Safety Executive (HSE) found that the company had not performed a machine specific risk assessment so the risk of entanglement in moving parts had not been highlighted. The employee had no previous experience of working on this type of machine and had not completed training. As employees were under pressure to carry out jobs quickly, they were feeding metal tubing into two rollers at a time. The company failed to recognise the dangers of using gloves when working with machinery, which was standard practice, as the company had not provided instruction on the correct procedures.

Dealercast Ltd of Barton Hall Industrial Estate, Hardy Street, Eccles, Manchester pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974. The company was fined £20,000 and ordered to pay costs of £3,661.

Director Christopher Ellor of Arncliffe Road, Bury, Greater Manchester pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974, by virtue of 37(1) of the Act. He was fined £1,280 and ordered to pay costs of £3,461.

Speaking after the hearing, HSE principal inspector Peter Lennon said: "Employers should ensure they carry out an assessment of the risks and put in place a safe system of work for the operation of all machinery. Companies should be aware of the responsibility upon company directors to recognise the way in which their employees are working. Employers should also be aware of the risk of entanglement when wearing gloves whilst operating machinery.

"Had the company put in place a clear system of work and prohibited the wearing of gloves when operating this machinery, the incident could have been avoided."

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](http://www.hse.gov.uk)
2. More about the legislation referred to in this case can be found at: [www.hse.gov.uk/pubns/books/122.htm](http://www.hse.gov.uk/pubns/books/122.htm)
3. HSE news releases are available at <http://press.hse.gov.uk>

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## [Pedestrian fatalities prompt HSE safety notice on use of wheeled loading shovels](#)

Britain's safety regulator has today, 25 October, issued a [safety notice](#) on the use of wheeled loading shovels, widely used in the waste and recycling sector.

The Health and Safety Executive (HSE) notice follows nine fatal vehicle-pedestrian collisions in the past four years. Six of these occurred in the waste and recycling sector, with the remainder involved moving wood chip.

HSE has identified issues of poor visibility caused by the bucket and load, the engine at the rear and the cab pillars, significantly reducing the drivers' ability to see pedestrians and, to a lesser extent, other vehicles. The use of larger capacity buckets, which has become common practice where low-density material is being moved, makes forward visibility significantly worse.

Regulation 4 of The Provision and Use of Work Equipment Regulations 1998 (PUWER) requires machinery to be suitable for the purpose for which it is used. This also applies if the equipment is adapted, for example by fitting a larger bucket.

Manufacturers and other specialist suppliers have attempted to address the problem by adding 'visibility slots' or mesh at the top of buckets, but evidence from investigations suggests these are ineffective when the bucket is in the carry position or obscured by the load. Camera systems have been under development for some time, but their effectiveness remains unproven and are not widely available.

Head of HSE's Waste and Recycling team, HM Principal Inspector of Health and Safety, Tim Small, commented:

“Poorly planned use of wheeled loading shovels can have fatal consequences. This safety notice reminds duty holders who use these machines of the need to fully assess and actively manage the risk of vehicle-pedestrian collisions. Currently, the only effective control measure is strict segregation of vehicles and pedestrians. If you cannot ensure that segregation, you should not use larger capacity buckets or wheeled loaders, but employ alternative work methods such as using different machinery and/or site management arrangements.

“Before using wheeled loaders – or making changes to them – you should review your workplace transport risk assessments to ensure they will be safe to use in your environment and in the way you intend to use them. By implementing appropriate risk controls, needless pedestrian deaths could be avoided.”

The safety notice can be viewed [here](#).

• ENDS –

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2. The safety notice can be viewed [here](#).
3. **Further information**

[Workplace transport safety – A guide to workplace transport safety \(HSG136\)](#)

[Workplace transport safety checklist \(hse.gov.uk\)](#)

[Safe Transport at Waste and Recycling Sites WASTE 09 – Waste Industry Safety and Health Forum \(WISH\)](#)

[Provision and Use of Work Equipment Regulations 1998 \(PUWER\) – Work equipment and machinery](#)

[Hand Sorting of Recyclables \(‘Totting’\) With Vehicle Assistance WASTE 18 – Waste Industry Safety and Health Forum \(WISH\)](#)

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# Site supervisor fined after worker suffered serious injuries

A site supervisor has been sentenced for safety breaches after a 46-year-old worker became entangled in a conveyor belt sustaining serious injuries to his hand and arm.

Leeds' Crown Court heard that, on 20 October 2016, an operative was working on a conveyor belt on an automated waste picking line at Associated Waste Management (AWM) Ltd in Canal Road, Bradford, when it became damaged and needed repair. Whilst the operative was working to repair the conveyor line, it started moving and his arm became entangled, which caused muscle and tissue damage.

An investigation by the Health and Safety Executive (HSE) found that AWM site supervisor Andrew Hughes, who had control of the site in the absence of the site manager, was responsible for completing a permit for the repair work and isolating the line. However, on his way to complete the permit he became distracted with another matter and the permit to work and isolation were not completed. This meant that the conveyor belt restarted during the repair work injuring the employee.

Andrew Hughes of Heathmoor Park Road, Illingworth, Halifax, West Yorkshire pleaded guilty to breaching Section 7 (1) of the Health & Safety at Work etc Act 1974. He was given a four-month prison sentence suspended for 12 months and ordered to pay costs of £1,000.

Speaking after the hearing, HSE inspector Darian Dundas said: "Mr Hughes failed to implement company policy and procedure in respect of permits to work and isolation.

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

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2. More about the legislation referred to in this case can be found at: [www.legislation.gov.uk/](http://www.legislation.gov.uk/)
3. HSE news releases are available at <http://press.hse.gov.uk><sup>[3]</sup>
4. Please see the link below to the page on HSE's website that is the best guide to doing it the right way: <https://www.hse.gov.uk/safemaintenance/permits.htm>

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## Car company fined after employee crushed at work

A car manufacturing company has been fined after an employee became trapped and suffered crush injuries whilst unloading a chassis from a delivery vehicle.

Kidderminster Magistrates' Court heard that the employee became trapped between the trolley holding the chassis and a parked vehicle when the delivery vehicle moved.

An investigation by the Health and Safety Executive (HSE) into the incident, which occurred on 18 April 2018, found that the company did not have a safe system of work for unloading chassis. The risks should have been controlled by offloading the chassis using a forklift truck or implementing a formalised system of work to safely unload them by hand.

Morgan Motor Company Manufacturing Limited of Pickersleigh Road, Malvern, pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974. The company has been fined £60,000.

Speaking after the hearing, HSE inspector Elizabeth Thomas said: "A safe system of work should have been in place and this shows that even large, well-established companies can get things wrong".

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## Lincolnshire food manufacturer fined after employee crushed in cooking

# machine

A Lincolnshire-based food manufacturer has been fined after one of its employees sustained two broken ribs having been crushed within an industrial cooking machine whilst working to clear a blocked water inlet.

Lincoln Magistrates' Court heard how the employee was crushed in the machine after its safety systems were over-ridden and the machine worked on whilst it was live. It should have been isolated before work on it began.

An investigation carried out by the Health and Safety Executive (HSE) found that the task was carried out by the employees in this fashion on a regular basis and that the company should have been aware . No risk assessment of the task had been completed and employees had not been provided with a safe system of work to carry it out. The lack of a safe system of work for the task and the company's failure to monitor how the work was done, led employees to devise their own way of conducting the procedure which included over-riding the safety systems and using unsafe working practices.

Bakkavor Fresh Cook Ltd of Sluice Road, Holbeach St Marks Spalding pleaded guilty of one breach of Section 2(1) of the Health and Safety at Work etc. Act 1974 and were fined £130,000 and ordered to pay costs of £2607.10.

At the end of the trial HSE inspector Tim Nicholson commented: "Those in control of work have a responsibility to devise safe methods of working and to provide the necessary information, instruction and training to their workers. If a suitable safe system of work had been in place prior to this incident, alongside good monitoring of the way the work was done, the injuries sustained by the employee could have been prevented."

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2. More about the legislation referred to in this case can be found at: [legislation.gov.uk](http://legislation.gov.uk)
3. Information regarding how to safely carry out maintenance tasks can be found on the HSE website at [hse.gov.uk/safemaintenance](http://hse.gov.uk/safemaintenance)
4. HSE news releases are available at <http://press.hse.gov.uk>