Double glazing company boss avoids jail after worker dies

The director of a Croydon-based double glazing company has avoided an immediate spell behind bars following the death a man described as “an anchor” by his devastated wife.

Ayman Noor was given a suspended prison sentence and his company – My Best Group Limited – was fined, following the death of 40-year-old Kashif Rehman on 12 November 2021.

Mr Rehman suffered a cardiac arrest when a number of toughened glass panels fell on him as he was trying to retrieve one from a stack leaning against a wall. The incident happened at the firm’s premises on Bensham Grove in Thornton Heath. He died three days later in hospital.

His wife Naila said her husband was ‘humble, kind and caring’ as she spoke about the impact of his death on their young family.

“I didn’t just lose my husband, I lost my anchor, my friend and my biggest support and motivator, she said.

“Kashif was humble, helpful, kind, caring, intelligent and God fearing and an amazing role model to three young sons. We once had a beautiful family of five, happy and content with sounds of laughter and positive moments. Now our home is filled with sadness, hollowness, emptiness and silence.

“Before switching off the life support machine, I had to give the news to my two, four and six-year-old sons that their daddy can’t come home. Those painful cries still ring in my ears and I have flashbacks to their painful tears. I always see my boys suffering even in the happiest celebrations, I see the sadness in their eyes and longingness for their dad.”

An investigation by the Health and Safety Executive (HSE) found that Mr Rehman’s death could have been prevented had the glass panes, weighing up to 10kg each, been restrained or stored in a suitable racking system to hold them in place.

Naila added: “I still have sleepless nights due to the anxiety and flashbacks from the day. I get vivid flashbacks from the day it happened, the drive to the hospital and the funeral. I also feel uneasy on Fridays as this is when the incident happened, where I just relive the trauma.”

The HSE investigation also found My Best Group Limited, had failed to assess the risks associated with storing and handling the panes of glass, implement a safe system of work and provide adequate training and supervision. Its director, Mr Noor, was aware of the failings but failed to implement the measures required to ensure the safety of his employees and members of the public that had access to the glass storage shed.

At Southwark Crown Court on 8 May 2024, My Best Group Limited, which is now in liquidation pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. The company would have been fined £120,000 but due to its liquidation status this was reduced to a nominal fine of £2,200. Director Ayman Noor was given 20 weeks and 14 weeks custodial sentences that will run concurrently, but they were suspended for 12 months. He will also pay costs of £9,294 for breaching section 37 of the same Act.

HSE inspector Marcus Pope said: “This is yet another tragic and avoidable workplace incident that should never have happened.

“Had My Best Group Limited implemented a suitable safe system of work for storing and handling glass Mr Rehman would still be here today. These tragic circumstances should demonstrate to the glass industry the importance of safe storage and handling of glass.”

This prosecution was brought by HSE enforcement lawyer Rebecca Schwartz.

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.
2. More information about the legislation referred to in this case is available.
3. Further details on the latest HSE news releases is available.

HSE issues MoD (Army) with Crown Censure following death of soldier

The Health and Safety Executive (HSE) has today (Wednesday 8 May) issued the Ministry of Defence (MoD) with a Crown Censure following the death of a soldier.

Conor McPherson, a private in the Black Watch, 3rd Battalion, the Royal Regiment of Scotland, lost his life during a training exercise at the Heely Dod firing range in Otterburn, Northumberland on 22 August 2016.

Conor’s father has said he was the model son.

The 24-year-old was part of a team-of-five when he was accidentally shot in the back of the head by a fellow soldier at around 11pm. He died at the

scene.

The group had been shooting at remote controlled targets as they manoeuvred on foot through the moorland firing range. They were using live rounds and night vision technology at the time.

A HSE investigation found the MoD (Army) failed to properly implement a safe system of work for the exercise.

The planning and conducting of the exercise was poor, and there was an ineffective system to monitor the management arrangements mandated within the MoD's own procedures. Mandated planning meetings in the lead up to the exercise were not attended by some staff.

Errors were made while producing written instructions and some staff lacked confidence while producing them. The finalised written instructions differed to how the exercise was being conducted. There should have been an additional supervisor with the firers on the night of the incident, due to the soldiers' lack of experience when carrying out night time firing.

Mandated 'night time' specific safety tasks were not carried out prior to firing commencing. Incorrect and unauthorised night vision equipment was being used by some soldiers. Officers who were not sufficiently experienced in controlling such an activity were not properly mentored or supervised to deal with an exercise of such complexity.

Neil McPherson, Conor's father, said in his victim personal statement: "Conor was a model son. He did not drink or smoke and he loved his family life. He loved books and his PC games and Saturday night films on TV.

"On the night Conor died, it was every parents' worst nightmare. A knock at the door, two men in suits bearing news that we had lost our son. I think we both went into shock but the memories of it all are blurred.

Conor McPherson (Credit: Ministry of Defence)

“The future is one of deep sorrow. Not to see Conor grow and find love and give us grandchildren is very sad. He would have been a fabulous father and as our only son there is no one to carry on the family name.”

By accepting the Crown Censure, the MoD (Army) has admitted breaching its duty under Section 2(1) of the Health and Safety at Work etc. Act 1974 and Regulation 5 of the Management of Health and Safety at Work Regulations 1999.

HSE inspector Jonathan Wills said: “Our thoughts are with the family of Private McPherson, with whom we have remained in close contact.

“Just like any other employer, the MoD has a responsibility to reduce dangers to its personnel, as far as it properly can.”

This HSE Crown Censure was brought by HSE enforcement lawyer Kate Harney and supported by HSE paralegal officer Rebecca Farman.

Mr McPherson added: “Socially, I don’t go out much anymore and Betty (Conor’s mother) hardly ever goes out socially except for a meal. I myself could not go back to work after Conor’s death. I don’t think I want to work anymore as I tend to shun being around groups of people. Betty and I have many pictures that to date, I cannot bear to look at although we often reminisce together. We also both have one of Conor’s dog tags each which we wear on a chain.”

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2. The MoD cannot face prosecution in the same way as non-Government bodies and a Crown Censure is the maximum sanction for a government body that HSE can bring. There is no financial penalty associated with Crown Censure, but once accepted is an official record of a failing to meet the standards set out in law.
3. More information on Crown Censures can be found here: http://www.hse.gov.uk/enforce/enforcementguide/investigation/approving-enforcement.htm [1]
4. 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].
5. Following investigations by Northumbria Police and the Royal Military Police, the Health and Safety Executive (HSE) was handed jurisdiction in December 2020.
6. The Crown Censure was issued on 8 May 2024 during a meeting held at the Army HQ in Andover. Lieutenant General Dame Sharon Nesmith DCB (Deputy Chief of the General Staff) formally accepted the Crown Censure from HSE on behalf of MoD (Army) and acknowledged the offences and deficiencies that led to the death of Pte McPherson.

Individuals and company sentenced after mother catapulted from fairground ride

Three individuals and a company have been sentenced after a mother-of-eight was catapulted from a fairground ride in Hillingdon, London.

Mrs Khadra Ali spent four months in hospital after she was ejected from the Xcelerator ride at the Funderpark funfair in Yiewsley on 10 April 2018. Her family continue to provide her with the support she needs after suffering multiple fractures to her back, hips, pelvis, ribs, both collarbones as well as internal bleeding and a significant head injury.

Mrs Ali, who was 45 at the time, went on the fast motion ride alongside her daughter but was not suitably restrained in her seat.

As the ride picked up speed, Mrs Ali, now 51, screamed for help and clung on for some time before being ejected.

Funderpark, Yiewsley

She hit the barrier of the next ride and landed on the ground.

She spent the next few weeks in a coma and four months in hospital as a result of her injuries. Mrs Ali can now no longer do chores or activities with her children.

The Health and Safety Executive (HSE) investigation found the ride's seat restraint system was designed with electrical and mechanical failings by the manufacturer, Perrin Stevens Limited. The ride control system was set up in such a way that it would not have detected all failures. Derek Hackett, the ride owner trading as Hackett Fairs, failed to properly maintain the ride, this was in part due to Perrin Stevens' operator manual lacking in information on inspection and maintenance of the seat restraint system.

The investigation also found on the day of the incident Mr Hackett's ride operator had no attendant assisting them despite the operations manual requiring a minimum of two people to operate and monitor the ride. Crucially, the operator did not check each rider's restraint bar as they should have before starting the ride, and did not notice that Mrs Ali required assistance and stopped the ride.


Funderpark, Yiewsley

DMG Technical Ltd was the appointed inspection body and had overall control of the in-service annual inspection of the ride and responsibility for issuing the declaration of the operation compliance (DOC). David Geary, director at DMG Technical Ltd, completed the annual inspection in 2017 and did not identify any failed switches or maintenance concerns. Mr Geary completed initial tests and signed off the ride for use in 2013. He also completed the required Design Review of the ride but failed to identify the electrical and mechanical design failings. The ride had been in use for a number of months before the design review was signed off by Mr Geary.

In 2023, HSE conducted an inspection campaign of fairgrounds, carrying out safety checks on rides currently in use in Britain. HSE's long-established guidance can be found at: Health and safety guidance for fairgrounds (hse.gov.uk).

At a hearing at Westminster Magistrates' Court on 7 May 2024:

- Perrin Stevens, of Oakley Green Road, Windsor, Berkshire, pleaded guilty as a director of Perrin Stevens Ltd (dissolved) that their offence under Section 6(1)(a) and Section 6(1a)(d) of the Health and Safety at Work etc. Act 1974 was attributable to his consent, connivance and/or neglect, whereby he was guilty of an offence contrary to Section 33(1)(a) by virtue of Section 37(1) of the Act. He was handed a custodial sentence of 32 weeks, suspended for 18 months, ordered to complete 150 hours of unpaid work and pay £11,444 in costs.
- Derek Hackett, of School Street, Manchester, pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974. He was given a custodial sentence of 18 weeks, suspended for 18 months, and ordered to pay £4,800 in costs.
- DMG Technical Ltd, of Wenlock Road, Hackney, London, pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974. The company was fined £51,000 and ordered to pay £30,000 in costs.
- David Geary, of Wenlock Road, Hackney, London, pleaded guilty to breaching Section 3(2) of the Health and Safety at Work etc. Act 1974. He also pleaded guilty as director of DMG Technical Ltd that their offence as attributable to his consent, connivance and/or neglect, whereby he was guilty of an offence contrary to Section 33(1)(a) by virtue of Section 37(1) of the Health and Safety at Work etc. Act 1974. He was handed a custodial sentence of 44 weeks, suspended for 18 months, and ordered to pay £24,000 in costs.

HSE inspector Helen Donnelly said: “Mrs Ali was simply enjoying a day out with her children in what she expected to be a safe environment. As a result she continues to suffer pain and significant impact to her everyday life.

“Good health and safety management often requires multiple precautions being put in place, and often by different parties. This incident shows that there are serious consequences when we do not fulfil our health and safety duties and become reliant on the actions of others to ensure the safety of workers and the public. Good health and safety is a collective effort and we must all take responsibility for the role we have in keeping people safe.

“While this investigation has been long and complex, we hope Mrs Ali and her family will find some comfort with the sentence and see that justice has now been served.”

A statement from Mrs Ali’s representative said: “The family of Khadra Ali is deeply relieved that the criminal prosecution has concluded following the tragic incident at the Funderpark Fun Fair. They are grateful to everyone who has supported them throughout this challenging process.

“While no outcome can undo the impact of the life-changing injuries on Khadra’s health and well-being, they hope this marks the beginning of their journey to rebuild their lives and provide her with the support she needs moving forward.

“The family remain committed to providing Khadra with the best quality of life possible.

“They respectfully request privacy as they continue to focus on caring for Khadra and facing the challenges ahead.”

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3. Further details on the latest HSE news releases is available.

Motorsport engineering firm fined for failing to ensure the health, safety and welfare of its employees

A motorsport engineering firm based in Kent has been fined after Britain’s workplace regulator identified numerous health and safety breaches.

Inspectors from the Health and Safety Executive (HSE) visited Hispec Motorsport Limited at its Dartford premises four times between February 2017 and July 2023.

The company – a specialist designer and producer of aftermarket brake upgrades for road, race, track, and kit cars – had failed to maintain work equipment and done little to prevent workers being exposed to metal-working mists that can cause asthma.

- HSE recently completed a successful campaign to highlight the dangers from metalworking fluids. Exposure to metalworking fluids – also referred to as ‘white water’ – can cause harm to lungs and skin through inhalation or direct contact with unprotected skin; particularly the hands, forearms and face.

The HSE inspections took place in February 2017, November 2021, April 2023 and July 2023. They found serious breaches of the law at each visit and enforcement notices were issued.


High voltage panel removed while machine in operation

The subsequent investigation found the business had not maintained work equipment and staff were seen operating Computer Numerical Control (CNC) machines with safety panels removed allowing access to dangerous moving parts. In addition, the company had done little to prevent employees from being exposed to water-mix metal working fluid mist, a known cause of Occupational Asthma and Occupational Hypersensitivity Pneumonitis.

Hispec Motorsport Limited, of Watling Street, Dartford, Kent, pleaded guilty to breaching Section 2(1) of The Health and Safety At Work Etc Act 1974. The company was fined £6,500 and ordered to pay costs of £7,378 and a victim surcharge of £2,000 at Westminster Magistrates' Court on 3 May 2024.

After the hearing, HSE inspector Sam Brown commented: "Our inspections identified multiple failings by this company to manage key risks associated with work undertaken in the engineering industry.


Acids being stored at a high level

“Employees were using unguarded machinery and being exposed to hazardous substances that can cause debilitating respiratory diseases. Numerous interventions by our inspectors revealed a consistent failure to meet the minimum legal standards.

“This prosecution demonstrates that we will not wait for an injury or ill-health to occur before prosecuting.”

This prosecution was brought by HSE enforcement lawyer, Iain Jordan and supported by HSE paralegal officer, Imogen Isaac.

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2. More information about the legislation referred to in this case is available.
3. Further details on the latest HSE news releases is available.
4. Helpful guidance about metalworking fluids is available

Recycling company fined £1.2m after worker hit by a wagon

A Yorkshire metals recycling company has been fined £1.2m after a worker was injured after being struck by a wagon at a processing site.

On 10 August 2020 an employee of CF Booth Limited was walking across the site yard in Rotherham when he was struck by a moving 32-tonne skip wagon. The man was not wearing his hi-vis jacket and did not see the wagon approaching. The wagon driver did not see the employee prior to the collision due to concentrating on manoeuvring the vehicle around some low-level skips which had been placed on the corner near where the employee was crossing the yard.

Following the incident, the man sustained a fractured skull and also fractured his collar bone in two places but has since made a full recovery.

The incident took place at CF Booth Limited’s site in Rotherham

A Health and Safety Executive (HSE) investigation found that at the time of the incident the site was not organised in such a way that pedestrians and vehicles could circulate in a safe manner. A suitable and sufficient workplace transport risk assessment was not in place for the segregation of vehicles and pedestrians. The company had failed to take steps to properly assess the risks posed by the movement of vehicles and pedestrians. The incident could have been prevented by adequately assessing the risks and implementing appropriate control measures such as physical barriers and crossing points.

Every workplace must be safe for the people and vehicles using it and traffic routes must be suitable for the people and vehicles using them. HSE has guidance on workplace transport with advice on keeping traffic routes safe and separating people from vehicles.

At Sheffield Magistrates' Court on April 25 CF Booth Limited of Clarence Metal Works, Armer St, Rotherham, pleaded guilty of breaching Section 2 of the Health and Safety at Work etc. Act 1974. They were fined £1.2million and ordered to pay costs of £5,694.85.

After the hearing, HSE inspector Kirstie Durrans said: "If CF Booth Limited had assessed the risks and ensured vehicles and pedestrians could circulate in a safe manner, this incident could have easily been avoided.

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

This HSE prosecution was brought by HSE enforcement lawyers Karen Park and Kate Harney, and supported by paralegal officer Rebecca Forman

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