

# MoD issued with Crown Censure by HSE after Marine recruit died during an exercise

The Ministry of Defence (MoD) has been issued with a Crown Censure by the Health and Safety Executive (HSE) after a Royal Marine recruit died during a routine training exercise.

On 21 January 2020, Royal Marine recruit Ethan Jones drowned while taking part in a training exercise involving a night beach landing at Tregantle Beach, Cornwall.

As the final part of their training, the recruits took part in an exercise which included disembarking from a landing craft into the sea and wading to shore. The depth of the water was deeper than anticipated and a number of recruits were submerged and had to be rescued. Recruit Ethan Jones was found floating next to the landing craft. Although he was recovered from the water and transported by air to hospital, he tragically died three days later.

HSE found the MoD failed to undertake a suitable and sufficient risk assessment, failed to properly plan, failed to properly supervise, and therefore failed to ensure the safety of their employees during what should have been a routine training exercise.

By accepting the Crown Censure, the MoD admitted breaching its duty under Section 2(1) of the Health and Safety at Work etc. Act 1974.

HSE inspector Emma O'Hara said: "This was a very serious incident which has resulted in the death of a young Royal Marine recruit at the start of his military career.

"Just like any other employer, the MoD has a responsibility to take all reasonably practicable steps to control the risks to the safety of its employees. In this case they have failed to do so.

"HSE fully recognises the importance of properly managed realistic military training but this does not mean the training itself should expose recruits to uncontrolled or inadequately controlled hazards. HSE expects training exercises to be properly planned and managed through suitable and sufficient risk assessments and safe systems of work."

## **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](https://www.hse.gov.uk)

2. The breach of law the Censure is being issued over is: Section 2(1) and Section 3 (1) of the Health and Safety at Work etc. Act 1974, which 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"*.
  3. 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.
  4. More information on Crown Censures can be found here: <http://www.hse.gov.uk/enforce/enforcementguide/investigation/approving-enforcement.htm>
  5. The [Code for Crown Prosecutors](#) 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](#)
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## [Health board fined following the death of an elderly patient and failure to comply with an Improvement Notice](#)

A Health Board has been fined following the death of a vulnerable patient who left a hospital ward unnoticed through an unsecured door.

The Health and Safety Executive (HSE) investigation concluded that Cwm Taf Morgannwg Health Board failed to act on previous absconding incidents, which would have better protected 74-year-old Lynwen Thomas, who went on to fall in icy conditions in the hospital grounds and suffer a fatal head injury.

On 13 November 2019 Mrs Thomas, a patient on Llynfi Ward at Maesteg hospital, who was a known wanderer, left the hospital after 8pm unnoticed by hospital staff. That evening was very cold with snow on the ground. Mrs Thomas fell on a path resulting in her fatal injury.

An investigation by the Health and Safety Executive found that despite previous absconding incidents, including one involving Mrs Thomas, no reasonably practicable measures were taken at Llynfi Ward until after the fatal incident to protect vulnerable patients from wandering and potentially coming to serious harm.

Following another patient absconding incident at Princess of Wales Hospital, HSE served an Improvement Notice on the Health Board on 30 September 2020. The Notice applied to the Bridgend locality and required the Health Board to assess the risk to patients from escaping, absconding or wandering. The Notice was not complied with by the due date.

Before Cardiff Magistrates' Court, Cwm Taf Morgannwg Health Board pleaded guilty to charges of breaching Section 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974 and were fined £850,000 with full costs awarded of £10,627.30

Speaking after the hearing, HSE inspector Helen Turner, said: "Lynwen Thomas was a vulnerable patient, and known to abscond. Cwm Taf Morgannwg Health Board had a duty to protect her and other patients on Llynfi Ward, and they failed to identify or act on absconding risk.

"Despite significant warnings, there was no risk assessment or physical security measures introduced to prevent vulnerable patients from leaving the ward unnoticed. This incident was easily preventable and the risks should have been identified."

A family statement issued on behalf of Lynwen Thomas said: "Our mother was the loving and kind heart of our family who always put others before herself, especially her children and grandchildren. She was an incredibly caring, loving, and selfless person.

"We are devastated to lose her under such tragic and preventable circumstances.

"Today's prosecution by the Health and Safety Executive is the first step towards establishing what happened to our mother and we are grateful for their professionalism and engagement with us as a family.

"We want everyone to know how wonderful, caring, and intelligent our mother was. She loved us all very much and we loved her in return. We miss her terribly and it's only when this is all over that we can start to properly grieve for her.

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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>
4. Contact HSE's media team for the full family statement on 0151 922 1221 or email [media.enquiries@hse.gov.uk](mailto:media.enquiries@hse.gov.uk)

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## Manufacturing company fined after worker loses part of hand

Laxtons Limited, a West Yorkshire manufacturing company, has been fined for safety breaches after a worker lost part of their hand in a textile machine.

On 24 March 2021 an employee of Laxtons Limited was running a number of textile machines. When he opened a guard to check on a build-up of fibres, he reached in to remove material, losing part of his hand.

An investigation by the Health and Safety Executive (HSE) found that one of the machines had a defective interlock device. This allowed the machine to continue running when the guard, which was located over a pair of in-running rollers and gears, was opened.

Laxtons Ltd of Baildon, Shipley, West Yorkshire pleaded guilty to breaching Regulation 11 (1) of the Provision and Use of Work Equipment Regulations 1998. The company was fined £15,750 and ordered to pay £759 in costs at Leeds Magistrates' Court.

HSE inspector Julian Franklin said: "Machine guarding should be in line with the appropriate standard, and regularly checked.

"This incident could so easily have been avoided by simply training staff in the safe and correct way of operating machinery, and regularly checking that safety devices are functioning."

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2. More about the legislation referred to in this case can be found at: [legislation.gov.uk/](https://www.legislation.gov.uk/)<sup>[2]</sup>
3. HSE news releases are available at <http://press.hse.gov.uk><sup>[3]</sup>
4. Please see the link below to doing it the right way when working with machinery: <https://www.hse.gov.uk/agriculture/topics/machinery/farm-vehicles.htm>

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## Company fined after gable wall collapses

A building company has been fined £40,000 after the unsupported gable wall of a house collapsed on to a neighbouring property leaving a resident with a fractured sternum and collarbone.

The wall fell during a home refurbishment project in which the existing property had been reduced to a shell with its roof, internal walls, and structural support members for both gable ends removed.

Temporary supports to prevent the collapse of both gable ends were not in place and the correct sequencing of works and co-ordination with the scaffolding contractor failed to take place, resulting in the collapse.

An investigation by the Health & Safety Executive (HSE) found that the incident at a house in Grange Road, Bushey, Hertfordshire, on 5 April 2021, could have been prevented by effective planning of the dismantling sequence of works.

Barote Construction Ltd of Clydesdale Avenue, Stanmore pleaded guilty to breaching Regulation 19 (1) of the Construction (Design and Management) Regulations 2015. The company was fined £40,000, ordered to pay costs of £686 and a victim surcharge of £190 at St Albans Magistrates Court on 6 July 2022.

Speaking after the hearing, HSE inspector Rauf Ahmed, said: "This serious incident could have been avoided if the company had implemented a safe system of structural support for the gable end walls to prevent collapse."

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# Workplace fatality figures published

- **123 workers died in work-related accidents in 2021/2022**
- **2,544 deaths in 2020 through past exposure to asbestos**

A hundred and twenty-three workers were killed in work-related accidents in Great Britain in the last year, according to figures published today (Wednesday July 6) by the Health and Safety Executive (HSE).

The annual data release covers the period from April 2021 to March 2022, during which time most pandemic restrictions were lifted and the economy began returning to normal.

The industries with the highest deaths were construction (30), agriculture, forestry, and fishing (22), and manufacturing (22); though agriculture, forestry and fishing has the highest rate of fatal injury per 100,000 workers.

The three most common causes of fatal injuries continue to be falling from height (29), being struck by a moving vehicle (23), and being struck by a moving object (18).

The 123 worker deaths in 2021/22 is lower than the previous year, though it is in line with pre-pandemic figures. There has been a long-term downward trend in the rate of fatal injuries to workers, though in the years prior to the coronavirus pandemic the rate was broadly flat.

A further 80 members of the public were killed following a work-related accident in 2021/22. This is an increase on the previous year but below the pre-pandemic level. This is likely to reflect the various COVID-19 restrictions in place.

The release of the annual figures coincides with the 50<sup>th</sup> anniversary this month of the publication of the Robens report. The landmark report led to the Health and Safety at Work Act in 1974, which ultimately led to the HSE being set up the following year.

Since then, Great Britain has become one of the safest places in the world to work with the number of workplace deaths and injuries falling significantly.

HSE's Chief Executive Sarah Albon said: "While Great Britain is one of the safest countries in the world to work, today's figures show we must continue to ensure safety remains a priority. Every loss of life is a tragedy, and we are committed to making workplaces safer and holding employers to account for their actions, as part of our mission to protect people and places."

The figures relate to work-related accidents and do not include deaths arising from occupational diseases or diseases arising from certain occupational exposures (including Covid-19).

The HSE has also published the annual figures for Mesothelioma, which is a cancer that can be caused by past exposure to asbestos. The figures show that 2,544 people died from the disease in 2020. This is in line with the average of 2,523 deaths over the previous eight years. Current mesothelioma deaths reflect exposure to asbestos that mainly occurred before the 1980s and annual deaths are expected to decline during the next decade.

**Ends**

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2. HSE news releases are available at: <http://press.hse.gov.uk>
3. Work-related fatal injuries: [Fatal injuries in Great Britain \(hse.gov.uk\)](http://www.hse.gov.uk/fatal-injuries)
4. Mesothelioma: [Mesothelioma statistics for Great Britain](http://www.hse.gov.uk/mesothelioma)