

# Construction company fined after employee sustains life changing injuries in roof fall

A construction company based in Chesterfield has been fined after a subcontractor hired to complete work on a roof fell from the roof joists to the concrete floor below sustaining life changing injuries.

Nottingham Magistrates' Court heard that, on 19 June 2019, Bobby Oldham Construction Limited (BOCL) were contracted to complete work on a domestic extension at Mona Road, West Bridgford, Nottingham. The work was to complete an extension to the rear of the property, which contained a skylight and wooden joists. Work had progressed to the point where roof joists were being attached. The joists were accessed using a ladder, which then led to an unprotected trestle platform. The subcontractor was sat astride one of the joists when it gave way causing him to fall. He landed on the concrete floor below sustaining serious injuries including brain trauma and a broken neck.



An investigation by the Health and Safety Executive (HSE) found that had the company properly considered the risks associated with this type of work, and planned the work at height more carefully the incident could have been easily avoided. The trestle platforms were missing suitable edge protection, and there was an absence of other suitable fall mitigation measures such as airbags. The work was not supervised, which would have identified the unsafe working methods, which could then be challenged by the company.

Bobby Oldham Construction Limited (BOCL) of Market Street, Staveley, Chesterfield, Derbyshire pleaded guilty of breaching Regulation 4(1) of the Work at Height Regulations 2005. They were fined £8,000 and ordered to pay costs of £3,515.

Speaking after the hearing HSE inspector Phill Gratton said: "This was a tragic and wholly avoidable incident, caused by the failure of the host company to implement safe systems of work, and failure to ensure that work at height was properly planned and appropriately supervised.

“This risk was further amplified by the company’s failure to undertake a number of simple safety measures including conducting pre-start checks on the training of workers, planning work to ensure that working methods were safe, and supervision to ensure that dangerous working methods could be observed and challenged.”

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

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## [Two care provider companies fined and a manager cautioned after employee stabbed](#)

A Liverpool care agency, that supports people with mental health issues, its manager and a care home have been fined after an employee was stabbed by one of its residents.

Liverpool Crown Court heard that on the 2 November 2014 an employee of Options for Supported Living was undertaking a regular scheduled visit to assist the transition of services for a resident from Fulwood Care Ltd at Amphill Road, Aigburth to Options for Supported Living. During the visit, the untrained Options employee was left alone in the kitchen with the individual despite the care plan stating that the resident, whose violence and aggression had been clearly identified, required the attendance of two care workers at all times. Whilst the employee was unaccompanied, the

resident crossed the kitchen and stabbed the employee in the right side of her neck.

While the employee made a physical recovery, she has suffered post-traumatic stress disorder (PTSD) and long-term psychological trauma and is still receiving counselling.

An investigation by the Health and Safety Executive (HSE) found that despite care plans and risk assessments being in place from the City Council, the NHS Mental Health Trust and Fulwood Care Limited, all of which indicated the high risk the individual posed to themselves and others, neither Fulwood Care Limited or Options for Supported Living took account of these documents prior to the visits by Options for Supported Living. This included the manager at Supported Living, Marie Binns.

It was also found that dedicated training and a full risk assessment and care plan for that individual were not undertaken by Options for Supported Living in order to identify the triggers for violence and aggression, and how the risk could be managed. The need for 2:1 supervision, triggers (things not to say or do) should have been identified and copies of the documents given to Options employees prior to their visits. Arrangements with regard to communication and supervision by the two care agencies should also have been undertaken and adequate supervision during visits provided by both Options and Fulwood Care.

Options for Supported Living Ltd of St Nicholas House, Old Church Yard, Liverpool, pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974 and was fined £31,000 and ordered to pay £10,000 towards costs.

Fulwood Care Ltd of Amthill Road, Aigburth, Liverpool pleaded guilty to breaching Section 3 (1) of the Health and Safety at Work etc. Act 1974 and was fined £14,000 and ordered to pay £10,000 towards costs.

Marie Binns of Queens Drive, West Derby, Liverpool accepted a formal caution with regard to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974.

HSE inspector, Rose Leese-Weller, said after the hearing: "This was a tragic and wholly avoidable incident. 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 the incident, the individual in care may not have reacted the way they did, and life changing injuries sustained and trauma experienced by the Options employee could have been prevented."

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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: [INDG69.R8 Violence at Work: A guide for employers.](#)
3. HSE news releases are available at <http://press.hse.gov.uk>

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## [Foundry fined after workers exposed to lead dust](#)

John Taylor Bell Foundry (Loughborough) Ltd was sentenced for safety breaches after workers were exposed to harmful lead dust during the repair and refurbishment of church bells at St Peter's church in Barton-Upon-Humber.

Grimsby Magistrates' Court heard that, part of the planned maintenance project on 20 March 2019 involved stripping off rust and old paint from the metal bell frame and fittings. After work had already been underway for some time, the old paint was confirmed to contain lead.

An investigation by the Health and Safety Executive (HSE) found that the workers who had been stripping the paint had been exposed to harmful lead dust because they had been using power tools (which generate excess levels of dust). The company did not have proper cleaning techniques and personal protective equipment (PPE) in place.

John Taylor Bell Foundry (Loughborough) Ltd of The Bell Foundry Freehold Street Loughborough pleaded guilty to breaching Regulation 5(1), of the Control of Lead at Work Regulations 2002. The company has been fined £13,000.00 and ordered to pay £6,469.90 in costs.

After the hearing HSE inspector, Jennifer Elsgood, commented: "The company's procedures for identifying lead, protecting workers from lead exposure during works and providing information and instructions to workers regarding lead were inadequate and resulted in a real risk to the health of those workers.

"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>
4. Please visit our website to find out the link below to work safely with lead:  
<https://www.hse.gov.uk/construction/healthrisks/hazardous-substances/lead.htm>

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## [Construction company fined after worker seriously injured by a mitre saw](#)

A construction company has been fined after a worker's hand was severed by an inadequately guarded mitre saw on a construction site in Bolney, Sussex.

Lewes Magistrates' Court heard that, on the 9 January 2019, a worker installing skirting board in a new build house was using a powered mitre saw to cut material to length. The guard of the saw had been propped up, meaning the full front of the sawblade was exposed. During the works, the mitre saw fell forward on to a worker's right-hand causing part of their hand to be severed. This was re-attached in surgery, although he has not regained full use of it.

An investigation by the Health and Safety (HSE), found that there was a systematic failure to ensure the mitre saw was properly guarded, and there was insufficient supervision on site.

Borrowdale Construction Homes Limited of Lancaster House Sopwith Crescent, Hurricane Way Wickford, Essex pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work Etc Act 1974. They were fined £21,000 and ordered to pay costs of £11,567.

Speaking after the hearing, HSE inspector Leah Sullivan said: "This incident could so easily have been avoided by simply ensuring that the correct control measures were in place and that safe working practices were being followed.

"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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## [Manufacturing company fined after worker suffered multiple electrical burns](#)

Glassflake Ltd has been sentenced after an employee received an electric shock while working inside a transformer cabinet.

Leeds Magistrates’ Court heard that, on the 7 June 2019, the worker was changing tappings on a transformer, which serves the tanks which melt glass, at a factory on Forster Street, Leeds.

An investigation by the Health and Safety Executive (HSE) found that he was working on the transformer supplying current to an electric heating element. He was found unconscious inside the rear of the transformer, with the transformer not isolated. His torch and spanner were on the floor of the cabinet, and he had significant burns to his chin and the back of his head

consistent with an electric shock passing from his chin to the side of the cabinet.

Glassflake Ltd of Forster Street, Leeds, West Yorkshire pleaded guilty to breaching Regulation 3 (1) (a) of the Electricity at Work Regulations 1989. The company has been fined £30,000 and ordered to pay £693.62 in costs.

After the hearing, HSE inspector Julian Franklin commented: "Working on live electrical systems exposes workers to significant risk of electric shock and should be avoided if reasonably practical".

"This incident could so easily have been avoided by simply carrying out the correct control measures, primarily by isolating the power supply first.

"HSE will not hesitate to take appropriate enforcement action against those responsible for electrical work that put their workers at risk."

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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. For more information on how to work safely around electricity, please visit here: <https://www.hse.gov.uk/toolbox/electrical.htm>

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