Building owner jailed after worker left paralysed

A building owner has been sentenced to 12 months in prison after an employee was left paralysed when a hoist platform he was working from plummeted from the third floor to ground level.

On 9 January 2017 an employee of Mr Nicholas Devine was working at a premise on School Lane, Seaforth, Liverpool where a floor of the commercial building was being fitted out as a recording studio. This required repairing the timber frame around the lift shaft and rehanging the doors. When standing on the platform of the goods lift, it fell to the ground floor without any warning, causing serious spinal and head injuries to a worker that resulted in paralysis of the lower half of the body.

An investigation by the Health and Safety Executive (HSE) found that the hoist had not been adequately inspected and maintained and was not suitable to support people when in the raised position. The hoist was not suitable for use with a platform to serve different levels without significant modification.

Further investigation revealed a similar accident had occurred a year earlier on 25 January 2016 when one of the building's tenants stepped onto the hoist platform to remove the load, which jolted and without warning dropped in an uncontrolled manner to the ground floor. The tenant suffered a broken heel bone.

Mr Devine had not ensured that the hoist was thoroughly examined at any time and following this earlier incident any work that may have been undertaken on the hoist was sub-standard and did nothing to protect people. He had not assessed the risk arising from the work or put measures in place to prevent access to the lift shaft.

At Liverpool Crown Court, Nicholas Devine formerly of Garthdale Road, Allerton, Liverpool pleaded guilty to breaching Section 2 (1) of the Health and Safety at Work etc. Act 1974 and was sentenced to 12 months imprisonment and was ordered to pay costs of £10,000.

HSE inspector Andy McGrory said: "This incident could so easily have been avoided. Nicholas Devine failed to ensure the health and safety of his employees in relation to the risks arising whilst work was being undertaken at his premises.

"Many incidents can be avoided by thoroughly planning work and taking simple precautions. However, plant and equipment installed at premises must be maintained and examined to ensure that it is safe for use by all."

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. For guidance on working safely: Lifting Operations and Lifting Equipment Regulations (LOLER) (hse.gov.uk)
4. HSE news releases are available at: http://press.hse.gov.uk

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Firefighters left seriously injured in quarry training exercise

A fire service has been prosecuted after two of its firefighters received serious head injuries – with one paralysed from the chest down – after a training exercise.

A team of four firefighters from Staffordshire Fire and Rescue Service were carrying out a rope rescue training exercise at a disused quarry near Buxton on 29th September 2019.

Two of the firefighters received head injuries when rocks fell from the cliff face and hit them.

An investigation by the Health and Safety Executive (HSE) found there were failures in the arrangements and controls of the exercise.

The risk assessment failed to consider or identify the risk of falling rocks and or the impact recent heavy rainfall may have had on the stability of the rock face.

The fire service didn't have the health and safety guidance for off-site training events.

The investigation also found that the service failed to provide sufficient information, instruction, training, and supervision to its firefighters.

Staffordshire Commissioner Fire and Rescue Authority of Pirehill Lane pleaded guilty to failing to discharge the duties imposed upon it by Section 2(1) of the Health and Safety at Work Act 1974. They were fined £10,000 And ordered to pay costs of £6,808.40

HSE Inspector Andrew Johnson said: "This was a particularly tragic and very sadly, completely avoidable incident that has had a life changing impact on a valued firefighter and their family. In this case, very simple and

straightforward precautions that would have prevented this incident were absent. I hope this underscores a very clear message to all companies and emergency services that when they plan their work at height training, it is planned meticulously and supervised appropriately in order to ensure that all necessary controls to ensure safety are used."

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Director and companies fined for failing to manage the risk of asbestos

Two engineering companies and their director have been sentenced for failing to manage the risks from asbestos to employees within the workplace.

A large quantity of asbestos containing materials, including asbestos insulating board, were identified during a HSE inspection at factory premises in Kidderminster owned by Kespar Engineering Limited in February 2019. The premises were occupied by SDF Automotive Limited (who went into administration in November 2019). Employees of both companies worked in the premises. The sole director for both companies was Peter Gerard Parkes.

An investigation by the Health and Safety Executive (HSE) identified the failure of all defendants to manage the risks from asbestos within the premises. This included the failure to ensure the suitable and sufficient assessment of the risks to the health of employees working there was carried out. The defendants were aware that asbestos was present within the premises and had previously prepared asbestos management plans however these were not reviewed or updated. The location and condition of the asbestos on site was not actively monitored and the risk of any exposure to asbestos containing materials was not adequately considered or controlled by the defendants.

Kespar Engineering Ltd of Stourport Road, Kidderminster, pleaded guilty to breaching Regulations 4 (10), 6 (1) and 11 (1) of the Control of Asbestos Regulations 2012. The company was fined £51,000 and ordered to pay costs of

£30,000.

SDF Automotive Limited (in administration) formerly of Stourport Road, Kidderminster, pleaded guilty to breaching Regulations 4 (10), 6 (1) and 11 (1) of the Control of Asbestos Regulations 2012. The company was conditionally discharged for two years.

Peter Gerard Parkes of Morville, Bridgnorth, pleaded guilty to several counts under Section 37 of the Health and Safety at Work etc Act 1974. These related to his individual failing as a Director of Kespar Engineering Ltd, SDF Automotive Ltd, and Smethwick Drop Forge Ltd in respect of the offences committed by the Companies under his control. Mr Parkes was given a 12 month suspended prison sentence, fined £9,000 and ordered to pay costs of £14,000.

The case was heard at Kidderminster Magistrates' Court.

Speaking after the hearing, HSE inspector Sarah Reilly, said: "It is important that all dutyholders including company directors recognise the importance of actively managing asbestos containing materials in non-domestic premises and ensure that the potential risk to health posed by the materials is controlled."

"Health and safety law places duties on organisations and employers – directors can be personally liable and held to account when these duties are breached."

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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
4. Further information about the duty to manage asbestos can be found at: https://www.hse.gov.uk/asbestos/managing/index.htm
5. Guidance on the role of Directors and business owners for leading health and safety at work can be found at https://www.hse.gov.uk/pubns/indg417.pdf

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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."

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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/
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