

Company sentenced after worker fall from height

Abbots Mead Limited, a building maintenance company based in Cheshire has been fined £20,000 for poorly managing work at height while carrying out repairs to a roof and cleaning the gutters of a commercial unit in Wolverhampton.

Dudley Magistrates Court heard that on 29 January 2021 while carrying out repairs works to a fragile roof of a commercial unit, an apprentice employee fell through a skylight. The employee fell approximately six metres to the concrete floor of the warehouse below contacting the racking on the fall. His injuries included fractures to the hip and wrist.

An investigation by the Health and safety executive (HSE) found that employees had not been informed they were working on a fragile roof and no measures had been implemented for working on a fragile surface. The company failed to properly risk assess the task and to provide the appropriate control measures to prevent a fall.

Abbots Mead Limited, of Knutsford Way, Sealand Industrial Estate, Chester, pleaded guilty to a breach of Regulation 4(1) of the Work at Height Regulations 2005 and received a £20,000 fine. Abbots Mead Ltd were also ordered to pay costs of £3,873 and a victim surcharge.

Speaking after the hearing, HSE Inspector Aaron Fisher said: "Falls from height remain one of the most common causes of work-related fatalities in this country and the risks associated with working at height are well known.

"Companies and individuals in control should be aware that HSE will not hesitate to take appropriate enforcement action against those that fall below the required standard."

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. HSE news releases are available at <http://press.hse.gov.uk>

Scottish care provider found guilty of Health and Safety breaches following death of a vulnerable adult

Care provider, The Richmond Fellowship Scotland, has been fined after being found guilty of health and safety breaches after a vulnerable adult with severe learning difficulties drowned in a bath.

Glasgow Sherriff's Court heard that on 10 June 2016, at Cherry Tree Court in Cambuslang, Glasgow, one of the residents, Margaret Glasgow, a vulnerable adult with severe learning difficulties, drowned in a bath within her flat in the early hours of the morning.

The Richmond Fellowship had supplied a baby monitor to alert support workers that Ms Glasgow was out of bed but a HSE investigation found that it was neither suitable nor sufficient as she was so light on her feet.

The two support workers, one of which was on her first shift at Cherry Tree Court and who also were supporting four different service users in four different flats, failed to hear that Ms Glasgow was out of bed.

Sometime during the early hours of the morning of 10 June 2016, she was able to run a bath in which she subsequently drowned. The water to the flat should also have been isolated but neither carer knew to do so.

HSE's investigation concluded that there were severe staff shortages at the time of Ms Glasgow's death which resulted in two carers who were not familiar with Ms Glasgow being put in charge of her care over-night. Richmond Fellowship had no specific induction procedures at Cherry Tree Court and relied on staff finding time to read the care plans after their shift had commenced. There were no clear shift plans to alert the support workers to the critical needs of the four people they were supporting and no clear instructions on how checks should be made.

Staff had raised concerns on a number of occasions after finding Ms Glasgow out of bed, but Richmond Fellowship had failed to put more appropriate measures such as door sensors or pressure mats in place.

The Richmond Fellowship Scotland of Cumbernauld Road, North Lanarkshire pleaded not guilty to charges under Section 3 of the Health and Safety at Work (etc) Act 1974 but were found guilty following a two-week trial.

The organisation was fined £450,000.

Speaking after the hearing, HSE inspector Kathryn Wilson, said: "This was a desperately tragic case which has left Ms Glasgow's family devastated.

“The baby monitor was a wholly inappropriate method of alerting staff that a resident was out of bed, being designed to alert a parent that a baby is crying or choking.

“Margaret Glasgow should have been safe at Cherry Tree Court but a failure by the Richmond Fellowship Scotland to identify and put in place simple and reasonably practicable safety measures resulted in two support workers being given insufficient information to protect this vulnerable lady in their care.”

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[Sea food processing company fined after fatality involving forklift](#)

A sea food processing company has been fined after a worker died following injuries sustained when she was run over by a forklift

Lerwick Sheriff Court heard on 31 January 2018, that Karen Allen’ an employee of QA Fish Ltd suffered significant leg injuries as a pedestrian, following a vehicular collision in Scalloway, Shetland.

A joint investigation by the Health and Safety Executive (HSE) and Police Scotland found that no site-specific workplace transport risk assessment had been carried out. The use of the forklift truck was critical for the function of the business and the company failed to provide suitable and sufficient control measures to ensure that pedestrians and vehicles could circulate in a safe manner in the exterior of the premises, particularly with regards to the forklift truck.

The company failed to implement effective arrangements for the management of health and safety and also failed to act on the advice of a health and safety

consultant several years prior to the incident.

QA Fish Ltd of Blacksness Pier, Shetland have pleaded guilty to breaching Section 2(1) and Section 33(1)(a) of the Health and Safety at Work Act 1974 and have been fined £80,000, to be paid within 12 months.

Speaking after the case HSE inspector Connor Gibson said "The tragic outcome of this incident clearly highlights why dutyholders must ensure that vehicle and pedestrian movements at their work site are properly assessed and adequately controlled. This fatal incident could and should have been prevented via suitable and sufficient control measures segregating pedestrians from vehicle movements."

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[Timber company fined after employee severs thumb](#)

A timber company has been fined after an employee suffered serious injuries when his thumb came into contact with a saw blade.

High Wycombe Magistrates' Court heard that on 13 February 2019, Maceij Rudnicki, was setting up the floor mounted band resaw for a production run when his hand was drawn towards the blade with the power feed on. The thumb on his right hand was severed when it made contact with an unguarded blade.

An investigation by the Health and Safety Executive (HSE) found that Watford Timber Company Limited had failed to take the machine out of use when the guard stopped working because it did not have adequate arrangements in place to check and monitor their machines to ensure that guards and other protective devices remained in good working order.

Watford Timber Company Limited of Olds Approach, Tolpits Lane, Watford pleaded guilty to breaching Regulation 11(1) of the Provision and Use of Work Equipment Regulations 1998 and Regulation 5 of The Management of Health and Safety at Work Regulations 1999. The company was fined £13,400 and ordered to pay costs of £5,358.05.

Speaking after the hearing, HSE inspector Nigel Fitzhugh, said: "The incident could have been easily avoided had the company taken the machine out of use and repaired the guard as soon as it became inoperable. Employers must ensure that machinery guarding is kept in good working order."

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