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| 1234567 | Legal Services  Briefing Note |
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**September 2024**

**News**

**Fatality in a Coventry Care Home**

Coventry City Council are investigating a death at work following the death of a worker at a non-Council owned residential care home in July 2024. Coventry City Council are investigating the matter under its statutory obligations.

**Workplace fatalities rise in the UK**

According to the Health and Safety Executive, 138 workers were killed in work-related accidents in 2023/24, compared to 136 fatal injuries in the workplace in 2022/23. The three most common cases of fatal injury in the workplace involve falls from a height, being struck by a moving vehicle, and being struck by a moving object. Workers aged 60 or over accounted for 34% of those killed, despite them making up only 11% of the workforce. Male workers accounted for 95% of all fatalities at work in 2023/24.

**HSE podcast on asbestos**

The HSE has created a podcast to discuss the legal obligation to manage asbestos in buildings, highlight where it is likely to be found (any building built before 1999) and explain why it is dangerous. It can be accessed here:

<https://hsepodcast.podbean.com/?utm_source=press.hse.gov.uk&utm_medium=referral&utm_campaign=duty-to-manage&utm_content=podcast>

**Recent Cases**

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| **Council fined as school technician loses finger**  **July 2024** |
| **Summary:** A local authority has been sentenced after a worker lost his finger while operating a machine. The worker lost his right finger when it was sliced off by a circular bench saw. He worked in the design and technology department and was using the saw to cut pieces of wood for a lesson. Whilst cutting the wood he felt pain in his right finger then realised his finger was on the bench.  The employee had used the saw many times but had not been trained on how to use it safely. The investigation found that West Sussex County Council, the local authority in charge of the school, had failed to ensure he was trained to use the bench circular saw.  The local authority was fined £16,000, ordered to pay £4,294.60 in costs and a victim surcharge of £190. |
| **Learning points:**   * Workers must be trained properly when using equipment, this extends to Schools. * Had proper training have been provided the incident might have been avoided. |

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| **Company fined £160,000 after worker loses legs**  **July 2024** |
| **Summary**: An employee lost both legs whilst working. He was picking orders at a warehouse. The employee was working near a forklift truck which was being used to load pallets of tiles onto a truck. The truck was carrying two pallets, one on top of the other but they were not secured. When the driver turned the vehicle both pallets became detached, with the upper pallet striking the employee crushing his legs. He had to have both legs amputated below the knee.  An investigation by the Health and Safety Executive found that the company had failed to ensure this area of the warehouse was organised so that vehicles and pedestrians were segregated in a safe manner and loads were secured.  The company was fined £160,000 and ordered to pay £4,478 costs. |
| **Learning points:**  There must be a safe system of work for activities where there is a risk of being struck by loads or workplace vehicles. Adequate control measures should be implemented which may include:   * Vehicles and pedestrians being segregated where possible * Loads being properly secured |

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| **Charitable trust fined following death of volunteer**  **June 2024** |
| **Summary:** A charitable trust has been fined after a volunteer died during restoration work on a canal. He was fatally crushed when a section of a wall collapsed onto him in an excavation.  The investigation found that the Canal Trust had failed to ensure the safety of volunteers who were working within the excavation. The temporary propping was inadequate and there was no clear method for the safe installation or removal of props during the renovation work.  The Canal Trust was fined £30,000 and ordered to pay £10,822 in costs.  A HSE inspector said: “This was a tragic and wholly avoidable incident. The situation which led to Peter’s death would not have arisen had the temporary structural works been properly planned and implemented to ensure a suitable safe system of work prior to the incident. “It is essential that those in control of work of this nature devise safe methods of working and to provide the necessary information, instruction, and training to their workers to ensure their safety.” |
| **Learning points:**   * H&S obligations apply to volunteers, not just employees. * Volunteers, as well as employees, must be included in risk assessments to identify significant risks and implement effective control measures. * Anyone undertaking such work must receive the same adequate training and information as any employee would do. |

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| **Wolverhampton company fined after worker hit by forklift truck**  **July 2024** |
| **Summary:** A manufacturing company based in Wolverhampton was fined £30,000 after a welder sustained serious injuries when he was hit by a reversing forklift truck. He sustained injuries including a fractured ankle and a broken elbow, and spent several days in hospital.  An investigation by the Health and Safety Executive found that there were inadequate measures to segregate pedestrians and vehicles at the site. It was common for forklifts to enter the areas whilst pedestrians were in close proximity.  Arrangements for monitoring the condition of vehicles was also found to be inadequate and poor maintenance regimes were in place. The forklift truck involved in the accident was in a poor state of repair, including a broken horn and excessively worn tyres. The risk assessment for workplace transport was not suitable and sufficient, and the company had received previous HSE advice in relation to workplace transport and in particular about vehicle and pedestrian segregation.  They were fined £30,000 and ordered to pay costs of £6,104. |
| **Learning points:**   * All equipment must be properly assessed and maintained. * As above, adequate control measures should be in place. * Workers and vehicles should be segregated where possible. |

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| **£240,000 fine for company after fall left man paralysed**  **July 2024** |
| An electrical transmission company has been fined £240,000 after a man was left paralysed from the chest down after a fall at work. He was working on a pylon in preparation for its demolition. Him and his colleagues were unaware that there had been previous work undertaken by another team to loosen the bolts on the pylon. This work had not been risk assessed and there were no systems in place to effectively record and communicate what had been done. In addition, the team that was sent to site that day was also under-staffed for the work being carried out.  An investigation by the Health and Safety Executive found that the company had failed to ensure that the work at height was properly planned, appropriately supervised, and carried out in a manner that was, so far as was reasonably practicable, safe. |
| **Learning points:**   * The company had not assessed the risks associated with bolt cracking. * Tasks should be adequately resourced * There must be a process for transferring work between teams and ensuring safety critical information is recorded and communicated effectively where different teams will be accessing a site. |

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| **Openreach fined following death of engineer**  **June 2024** |
| Openreach Limited has been fined after an engineer died whilst trying to repair a telephone line. The employee died after he slipped and fell into the River Aber and was swept away.  An investigation found that a number of engineers had been attempting to repair the telephone lines, which ran across the river, over a period of two months. They had been working both near and in the river. At the time of the incident, there had been flooding in the area which meant the river was higher and faster flowing than usual. The employee entered the water and made his way to an island in the middle of the river in order to try and throw a telephone cable across to the other side by taping it to a hammer and then throwing the hammer. Whilst attempting to cross the river, he slipped and the force of the river swept him away. The investigation found that there was no safe system of work in place for work on or near water, nor had the employees received training or instruction on safe working on or near water.  Openreach Limited was fined £1.34 million and ordered to pay costs of £15,858.35. |
| **Learning points:**  Training must be given that relates to the specific task to be completed where there is a foreseeable risk. |