School Academy Trust fined £300,000 after student death

A school academy trust has been fined £300,000 after a 19-year-old student died as a result of a ‘series of management failures’.

Owen Garnett, who was described by his family as having “an incredible sense of humour” and who had “everything to live for” died two days after choking on a paper towel at Welcombe Hills School in Stratford-upon-Avon on 9 January 2023.

The teenager was a Sixth Form student at the school, which is for children with special educational needs and part of the Unity Multi Academy Trust (MAT). He had been diagnosed with Pica – a potentially life-threatening eating disorder where sufferers have a compulsion to eat things which have no nutritional value. He had been a student at the school since the age of 11. Despite a near miss incident just days earlier, the school failed to take action to make sure it didn’t happen again.

An investigation by the Health and Safety Executive (HSE) found that none of the staff in Owen’s class team had received any specific training on the management of safety risks associated with Pica.

Owen Garnett died two days after choking on a paper towel at his school

Before she died, Owen’s grandmother Maureen Garnett provided a statement alongside her husband Cliff.

“After Owen had passed away we never slept, we never ate, all we could do was cry,” they said.

“This lasted for months.

“This was supposed to be a place where Owen was safe and secure and happy.

“Owen had Pica and should have been kept under close supervision at all times and I can’t understand why this didn’t happen.

“We would describe Owen as a unique, lovable, challenging and caring and happy child.

“He will never be forgotten and our family will never get over this.”

The HSE investigation also found that students at the school have individual risk assessments which detail any specific health and safety risks, which relate to them, and the control measures that need to be in place at to protect against that risk. The risk of choking associated with Pica was identified on Owen’s risk assessment and a “named person” was supposed to supervise him to make sure he did not eat anything that could cause him harm.

On 9 January 2023, Owen was out in the playground area with other students during a break from class, unsupervised, and found his way back into school. It took several minutes for his absence to be noticed and when he was found, it was around the side of the building, and he was choking. Emergency services were called, and although they retrieved a ball of paper towel from his throat, he had been without oxygen too long and later died in hospital. Days before, there had been a similar incident with Owen, where he was seen in the playground by a teacher, again choking on blue towel, but Owen managed to clear his airway on his own.

The school failed to ensure that all the safety risks associated with Pica hazards, such as, in Owen’s case, the garden area, or supplies of paper towels, were correctly identified and that the preventive and protective measures including supervision, were organised in such a way as to protect him. They also failed to effectively investigate and respond to the concerns raised by his family.

His foster parents, Jacqueline and Graham Blackwell, said the day Owen died had started out as any other.

“Owen got up and had his breakfast,” they said.

“I can still remember him waiting excitedly for his usual taxi driver to pick him. He gave me a cuddle and then left for school.

“Owen was part of our family, we had made so many adjustments and made so many plans so that he could remain with us indefinitely.

“We had been saving to take him to Florida to swim with dolphins, but this is something he will never get to do. We ended up having to use this money to cover the cost of Owen’s funeral.

“His death has ruined every part of our lives.

“Owen had everything to live for and was such a character and used to love joking and playing about – he had an incredible sense of humour.”

- HSE guidance states that when assessing the health and safety risks to

individual students is necessary, educational employers should follow a risk management approach that focuses attention on the real risks; involving employees, students and carers in identifying the individual's needs and necessary precautions.

Unity MAT, c/o Woodlands School Packington Lane, Coleshill, Birmingham, pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. They were fined £300,000 and ordered to pay £10,750 in costs at Coventry Magistrates Court on 18 December 2024.

HSE inspector Rebecca Whiley said: "This tragic incident could have easily been avoided if Owen was being closely supervised, as he should have been.

"The near miss incident a few days before should have raised the alarm with the school and triggered an investigation into how Owen had been able to access the paper towel, and steps could have been taken to prevent it happening again.

"His death resulted from a series of management failures throughout Owen's time at the Hub, and a failure by the school to act on the concerns raised by his family.

"Our thoughts today are with Owen's family. He was a young man with a happy life ahead of him. He should have returned home safely to his family after a day at school, but because of the failings by Welcombe Hills School and Unity MAT, he did not."

This HSE prosecution was brought by HSE enforcement lawyer Arfaq Nabi and paralegal officer Sarah Thomas.

Further information:

1. The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. We are dedicated to protecting people and places, and helping everyone lead safer and healthier lives.
2. More information about the legislation referred to in this case is available.
3. Further details on the latest HSE news releases is available.
4. HSE does not pass sentences, set guidelines or collect any fines imposed. Relevant sentencing guidelines must be followed unless the court is satisfied that it would be contrary to the interests of justice to do so. The sentencing guidelines for health and safety offences in England and Wales can be found here and for those in Scotland here.
5. HSE guidance on supporting pupils with disabilities, special educational needs and additional support needs is available.

Drinks giant fined after worker sustains serious burns

An international drinks manufacturer has been fined half a million pounds after an employee sustained burns to over 30% of his body.

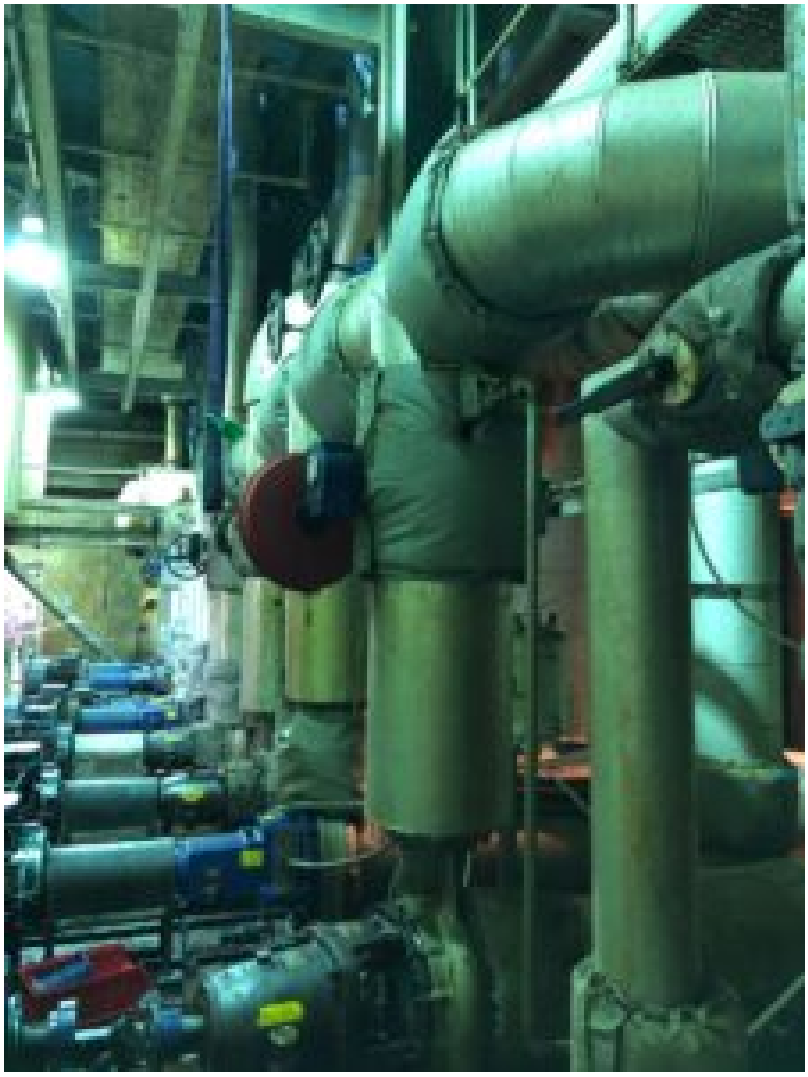
The mechanical engineer had been repairing a defective pump at Diageo's Glenlossie Distillery Complex in Elgin on 24 March 2021 when he was burned by pot ale.

The liquid, which had a temperature of 104 degrees Celsius, came out suddenly and unexpectedly from a pipe.

The worker sustained burns to his arms, hands, shoulders, back, chest, lower legs and ankles, before spending two weeks in intensive care where he was placed in an induced coma.

A Health and Safety Executive (HSE) investigation found Diageo failed to do all that was reasonably practicable to ensure maintenance operations could be carried out without a worker being put at risk of injury.

HSE guidance on the safe isolation of plant and equipment is freely available and provides steps to prevent the release of substances that are hazardous including hot, flammable and toxic substances. The guidance can be found at The safe isolation of plant and equipment – HSG253


The incident took place at Diageo’s Glenlossie Distillery Complex

Diageo Scotland Limited, of Lochside Place, Edinburgh, pleaded guilty to breaching Sections 2(1), 2(2)(a), 2(2)(c), 33(1)(a) and 33(1)(c) of the Health and Safety at Work etc. Act 1974. The company was fined £500,000 at Inverness Sheriff Court on 16 December 2024.

HSE inspector Isabelle Martin said: “This incident could so easily have been avoided by ensuring that procedures were in place to ensure that changes to work equipment installed in the plant were safe. However, more importantly Diageo should have had procedures in place to ensure that plant could be isolated safely and prevent the release of hazardous and dangerous substances.

“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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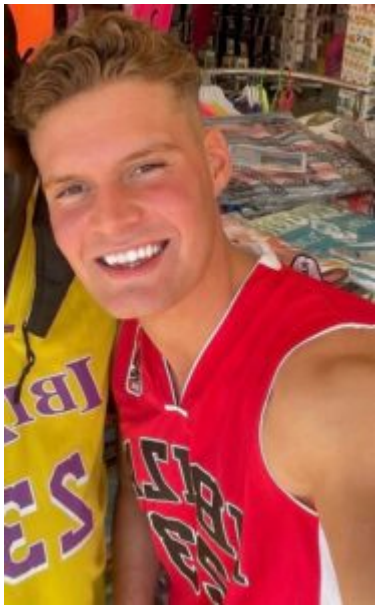
Company fined after worker “full of hopes and dreams” dies at wind farm construction site

An engineering company has been fined after a labourer died during the construction of a wind farm on the Shetland Islands.



Picture of Liam MacDonald

Liam MacDonald, from Tain, Ross-shire, lost his life on the morning of 5 June 2022 while removing dried concrete from a skip at the Viking site on Upper Kergord.

His mother has said the 23-year-old was “full of hopes and dreams” and is now missed “beyond words.”

Mr MacDonald, an agency worker who had started working on the site just over a month earlier on 4 May 2022, had been using a hammer to chip away the concrete when the skip’s bale arm fell on top of him.

The 23-year-old was found motionless with the skip’s bale arm pinned against his chest, which led to an alarm being raised at the site.

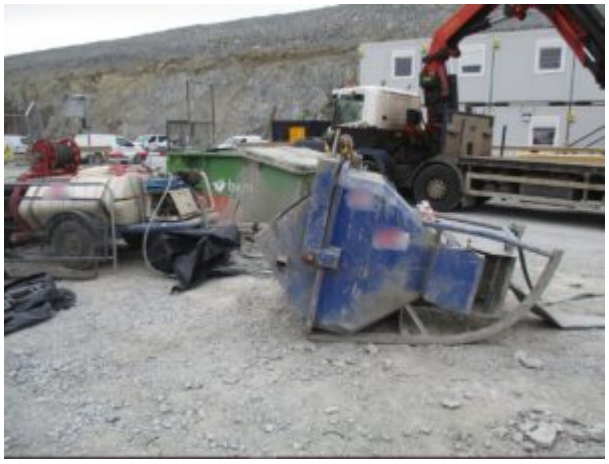
Colleagues subsequently performed CPR on Mr MacDonald, before administering a defibrillator, but he was sadly pronounced dead at the scene by the emergency services.

Jackie Randell, the investigating inspector from the Health and Safety Executive (HSE), found the principal contractor BAM Nuttall failed to secure the bale arm from falling.

The HSE investigation found the company had failed to identify the risks of the bale arm falling and failed to put in place a safe system of work to ensure that anyone using, maintaining or cleaning the skip would be protected from harm

Wendy Robson, Mr MacDonald's mother, said: "Liam loved life, his family and friends. He was just at the start of his adult life, still finding who he was, and full of hopes and dreams.

"We have been robbed of having Liam here today, and in all our tomorrows, and in sharing those dreams with him. We will never meet the children he so wanted to have one day.


Picture of skip

"We can't adequately describe who Liam was, and what he means to us. We love and miss him beyond words."

BAM Nuttall Limited, of Knoll Road, Camberley, Surrey, pleaded guilty to breaching Section 2(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined £800k with a £60k victim surcharge at Inverness Sheriff Court on 18 December 2024.

Jackie Randell said: "This was a tragic incident which led to the death of a young man. Our thoughts remain with Mr MacDonald's friends and family at this time.

"BAM Nuttall had failed in its duty to ensure the safety of their workforce. This prosecution should serve as a reminder for all contractors to implement suitable risk assessments and safe systems of work.

"We thoroughly investigated this incident, with our findings identifying that BAM Nuttall had failed in its duty to ensure the safety of their workforce.

This prosecution should serve as a reminder for all contractors to implement suitable risk assessments and safe systems of work.

“Up to date safety information provided by manufacturers of work equipment must be reviewed as part of this risk assessment process. It is of crucial importance that safety information from manufacturers is highlighted to the workforce and rigorous monitoring is carried out to ensure that everyone is kept safe.”

Debbie Carroll, who leads on health and safety investigations for the Crown Office and Procurator Fiscal Service (COPFS) said: “The death of Liam MacDonald could have been prevented if BAM Nuttall Limited had suitably and sufficiently assessed the risks involved in the maintenance and cleaning of the concrete column skip at the site.

“Their failure to identify the hazards represented by the skip’s bale arm and ensuring that it was secured prior to the cleaning operation beginning led to Mr MacDonald’s death.

“My thoughts are with his family and friends at this difficult time.”

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5. Further guidance can be found at: Provision and Use of Work Equipment Regulations 1998 (PUWER) – HSE

Fine for fairground operator after man ‘everyone fell in love with’ dies

A fairground operator has been fined after a man ‘everyone fell in love with’ died weeks after suffering serious head injuries while working on a ride in South Shields.

Dean Cariss was struck by a moving car on a rollercoaster ride while daily testing and maintenance was being carried out at Ocean Beach Pleasure Park on

19 March 2023.

The 52-year-old sustained severe head injuries and as a result died in hospital 13 days later.

A Health and Safety Executive (HSE) investigation found that Premier Attractions Limited had failed to ensure the health and safety of employees. The company pleaded guilty and was fined £28,000 at South Tyneside Magistrates Court on 17 December 2024.

Dean Cariss was struck by a moving car on a rollercoaster ride at Ocean Beach Pleasure Park

Mr Cariss, who had been with his partner Helen Wright for more than 15 years, was also a step father to Helen’s three grown-up children, as well as being a step grandparent to nine.

In a written statement provided to the court, Helen said: “Dean had a fantastic relationship with my kids.

“He also idolised his grandchildren, and treated them like his own.

“He was bubbly and fun and would do daft things with them.

“He was very generous and liked to help people.”

That helpful and generous nature also included him acting as Helen’s carer for several years.

“My whole life has been turned upside down and back to front,” she went on to say.

“He would move heaven and earth for me.

“He was a big personality and I miss the fun and laughter.

“Silence is deafening when I am in the house on my own.

“Everybody fell in love with him when they met him. There was no serious side, just laughter and fun.”

The investigation by HSE found that Premier Attractions Limited had failed to ensure the health and safety of employees. It was found that a suitable and

sufficient risk assessment had not been carried out and proper controls had not been employed to prevent employees accessing dangerous areas whilst the ride was operating.

Premier Attractions Limited of Little Hulton, Manchester, pleaded guilty to failing to comply with section 2(1) of The Health and Safety at Work etc Act 1974 – an offence contrary to s.33(1)(a) of that Act. They were fined £28,000 and ordered to pay £5,976 costs.

HSE Inspector William Gilroy said: "This tragic incident led to the avoidable death of a caring, family man.

"Dean's death could easily have been prevented if his employer had acted to identify and manage the risks involved, and to put a safe system of work in place.

"Companies should be aware that HSE will not hesitate to take appropriate enforcement action against those who fall below the required standards."

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Council fined after employees exposed to risks from vibrating tools

A worker who repaired potholes was diagnosed with Hand Arm Vibration Syndrome (HAVS), an occupational disease, following repeated exposure to vibration tools.

This week, his employer, Rotherham Metropolitan Borough Council has been fined following a prosecution by the Health and Safety Executive (HSE).

Sheffield Magistrates' Court heard the employee worked in the road maintenance department, carrying out tasks including repairing potholes, for

more than 20 years, using vibrating tools.

Prolonged and regular exposure to vibration can affect a worker's health resulting in painful and disabling disorders of the nerves, blood supply, joints and muscles of the hands and arms. These disorders are collectively known as Hand-Arm Vibration Syndrome (HAVS). The risk of onset or worsening of HAVS increases with daily exposure and varies widely between individuals. HSE guidance can be found here.

Employers are legally obliged to report cases of HAVS to HSE. The HSE investigation revealed that despite the worker in question receiving this diagnosis in April 2005, he continued to work with vibrating tools for a further 14 years.

The employee had been subject to regular health surveillance whilst employed by the Council, which had included recommendations on limiting exposure. However despite the report of April 2019, little action was taken to address the issues identified. Only once the HSE investigation had started in late 2019 was the man told to stop using vibrating tools.

The investigation also found that other employees continued to work with vibrating tools after they had been diagnosed.

While a system of Occupational Health surveillance was in place, it was inadequate as there was either no implementation, or inconsistent implementation, of the recommendations and actions to be taken. Recommendations following health surveillance of employees wasn't acted upon or used to identify risks.

The investigation found that the data used to calculate the vibration exposure grossly underestimated the vibration magnitude of the tools in use, and also relied upon accurate times being entered by staff. Workers were incentivised to continue using vibrating tools through a bonus scheme and overtime work which inevitably led to high levels of exposure. Workers were allowed to work up to the recommended Exposure Limit value (ELV), and in light of the inaccurate data inevitably worked beyond it on a regular basis. They were then only moved to other tasks when their health deteriorated.

Rotherham Metropolitan Borough Council pleaded guilty to an offence contrary to Section 33(1)(a) of the Health and Safety at Work etc Act 1974, for their failure to ensure, so far as was reasonably practicable, the health, safety and welfare at work of their employees in accordance with section 2(1) of the Act. On Tuesday 17 December, the Council was fined £60,000 and ordered to pay full costs of £5,775.70.

Following the hearing Kate Harney, enforcement lawyer for HSE said: "Rotherham Council had been exposing employees to the risks arising from the use of vibrating tools for a significant period of time. They fell below expected standards and appropriate enforcement was taken by the HSE.

"This was also not an isolated incident, with other staff working in the council's road maintenance division also exposed to risks to their health,

due to an unhealthy working culture where these exposures inadequately monitored.

“We urge those responsible for work using vibration tools to please check our freely available guidance.”

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5. HAVS is an occupational disease reportable under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).