Cheshire farm owner fined after roofer dies in fall

A Cheshire farm owner has been fined after a man fell to his death from a forklift truck while attempting to repair the roof of a packing shed at his premises in Tarporley.

Denis Thornhill and his company D.S. Thornhill (Rushton) Limited were fined a combined £16,000 after 64-year-old Mark Young was killed at Moss Hall Farm on 1 February 2021.

Earlier this year, both Thornhill and the company been found guilty of breaching health and safety legislation following a six-week trial at Chester Crown Court. The jury cleared 78-year-old Thornhill on a charge of gross negligence manslaughter. They returned to the same court on 11 October 2024 to be sentenced.

During the trial, the court was told that on 29 January 2021, Mr Young, who worked as a roofer, had been asked to make repairs to a roof panel and fix a blocked gutter on the same building. However, as he was walking across the roof, he damaged a second roof panel so a replacement was purchased to carry out an additional repair.

Mark Young had been lifted up to the roof using this forklift truck

He returned with his son three days later to complete the work and asked to be raised up to do it. Denis Thornhill arrived with a forklift truck that had a potato box balanced on its forks. Mr Young was lifted up inside the potato box to a height of around 16 feet, while his son, who was on the roof, attempted to reposition the panel from above. As Mr Young moved to one side of the potato box, it caused it to overbalance and he fell to the floor sustained serious head injuries.

Although paramedics were called, they were unable to resuscitate him and he was pronounced deceased at the scene.

HSE Inspector Ian Betley said after the hearing: “This was a tragic incident that could so easily have been avoided.

“The forklift truck and potato box were the wrong pieces of equipment for the job and never a suitable platform for working at height. The work should instead have been carried out using a tower scaffold, scissor lift, or a cherry picker.

“In bringing the forklift truck and potato box and using it to lift Mark at height, the company was in control of the work but had failed to implement proper planning and safe execution of it.

“All companies have a legal duty to ensure the safety of workers they employ or who carry out work for them. If that had happened in this case, then Mark’s life wouldn’t have been lost.”

The potato box used to lift Mark Young was unsecured to the forklift truck with him inside it

A joint investigation by Cheshire Constabulary and the Health and Safety Executive (HSE) found that on the day of the accident there was no safe system of work implemented for working at height and unsuitable work equipment was used. The potato box did not have the required safety features for a non-integrated work platform and had not been secured in a way to prevent it overbalancing. Additionally, the forklift truck had not been subjected to a thorough examination at the required frequency and was unsuitable for lifting people and Denis Thornhill was not formally trained in operating the forklift truck. Enforcement action was taken and a Prohibition Notice was served on the company prohibiting further work until a safe system was devised.

Denis Thornhill of Eaton Lane, Tarporley, Cheshire was cleared of manslaughter but was also found guilty of breaching Section 37 of the Health and Safety at Work etc. Act 1974, by virtue of 37(1) of the Act and was fined £4,000 and ordered to pay costs of £4,000.

D.S. Thornhill (Rushton) Limited of Moss Hall Farm, Moss Hall Lane, Tarporley, Cheshire was found guilty of breaching Section 3(1) of the Health

and Safety at Work etc. Act 1974 and was fined £12,000 and ordered to pay costs of £10,000.

Notes to editors:

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.

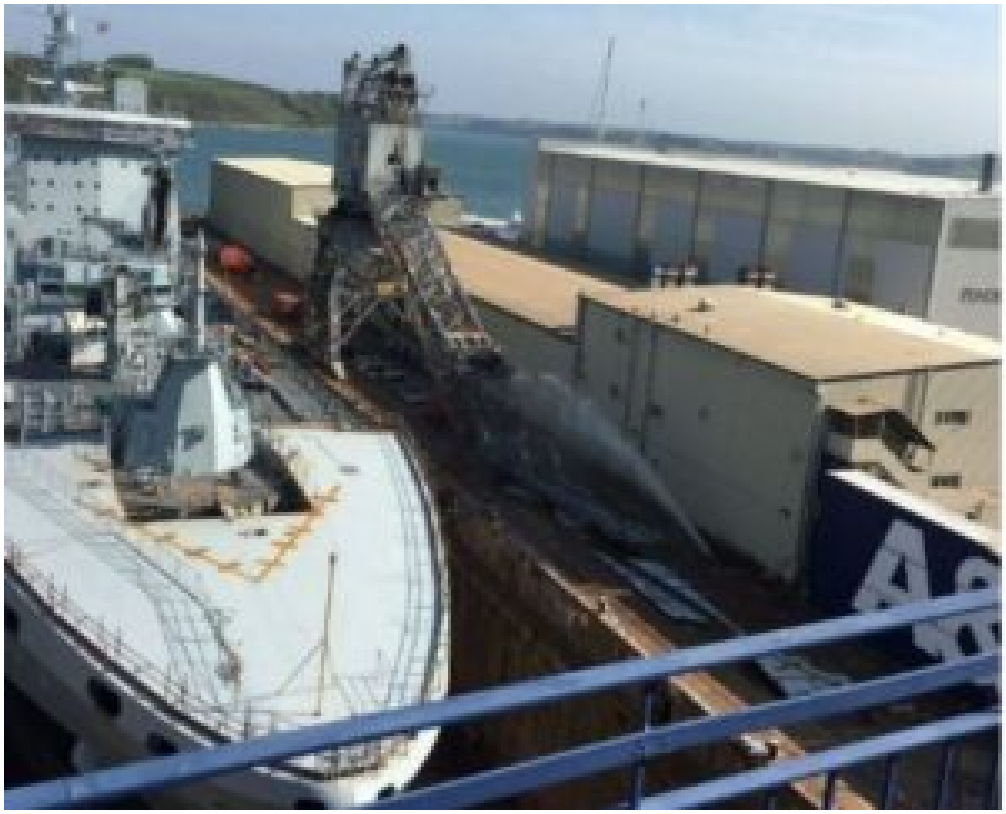
Company fined following crane collapse

A company has been fined after a crane collapsed at its site on Falmouth Docks, putting more than 250 people at risk.

Emergency services declared a major incident following the collapse at A&P Falmouth on 10 May 2017 with the surrounding area being evacuated and cordoned off.

The crane had been operating above Royal Fleet Auxiliary (RFA) ship, Tidespring, when the driver noticed the jib was descending uncontrollably.

The driver managed to move the crane away from RFA Tidespring and over the dockside before it collapsed, with the jib landing on a cage of acetylene cylinders.


The incident took place at Falmouth Docks

There were approximately 258 workers on site at the time.

A Health and Safety Executive (HSE) investigation found A&P Falmouth had failed to properly maintain the crane. Although the crane had been examined by a third-party, its recommendations regarding defects were not acted on by A&P Falmouth.

HSE guidance can be found at: Lifting Operations and Lifting Equipment Regulations (LOLER) (hse.gov.uk)

A&P Falmouth Limited, of Wagonway Road, Hebburn, Tyne and Wear pleaded guilty to breaching Section 2(1) and Section 3(1) of the Health and Safety at Work etc. Act 1974. The company was fined £750,000 and ordered to pay £26,792.30 in costs at Truro Crown Court on 11 October 2024.

HSE inspector Melissa Lai-Hung said: “This was a very serious incident and it is fortunate nobody was injured or killed as a result of this catastrophic failure at Falmouth Docks.

“We thoroughly investigated this incident and found that A&P Falmouth Limited’s system of maintenance was not effective in preventing the collapse of the crane.

“This case not only highlights the importance of regular proactive maintenance but also the inspection of lifting equipment. Companies looking for advice in these areas can find readily-available and free guidance on the HSE website.”

This HSE prosecution was brought by HSE enforcement lawyer Vicki Hanstock and supported by HSE paralegal officer David Shore.

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Cosmetics firm fined after HSE inspection found serious failings

A cosmetics company in Yorkshire has been fined more than £50,000 after an inspection by Britain's workplace regulator uncovered serious electrical failings.

Inspectors from the Health and Safety Executive (HSE) conducted an unannounced inspection at the premises of Sabel Cosmetics Limited on Pellon Lane in Halifax on 5 July 2022.

During the visit, the inspectors uncovered electrical deficiencies that posed serious risks of both electric shock and electrocution to workers.

HSE found there was a systemic failure within the company to address the risks identified with the electrical systems

A subsequent investigation by HSE found there was a systemic failure within

the company to address the risks identified with the electrical systems. The inadequate construction and maintenance of the electrical system at the premises presented an immediate risk of employees coming into direct contact with exposed live parts on equipment and machinery within the company premises. The company allowed the breaches to subsist over a long period of time.

Sabel Cosmetics Ltd of Pellon Lane, Halifax, West Yorkshire pleaded guilty to breaching Regulation 4 (1) of the Electricity at Work Regulations 1989. The company has been fined £56,695 and ordered to pay £5,949 in costs.

After the hearing, HSE inspector Andrea Jones commented: “This case shows the importance of HSE inspections to help ensure health and safety risks are being managed effectively and protect people at work.

“It is essential that electrical wiring installations and electrical equipment are constructed and maintained in a safe condition to prevent injuries or even worse, death.

“In this case, simple inexpensive steps could have been taken to remedy the most serious defects, instead the company’s inaction has resulted in more than £60,000 in fines and costs.”

Notes to editors:

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 about electrical safety is available.

World Mental Health Day: “Employers risk losing valued employees if stress is not managed”

Bosses across the whole of Great Britain have been warned that they risk

losing valued team members if they fail to manage their workers' stress levels in the workplace.

The Health and Safety Executive (HSE) is reminding British employers of their legal duties on World Mental Health Day (10 October).

HSE's Working Minds campaign provides readily-available and free resources for employers to help recognise the signs and tackle the root causes of stress.

Around half of work-related ill health is down to stress, depression or anxiety with each person suffering taking an average of 19.6 days off work.

Kayleigh Roberts, Work-Related Stress Policy Lead at HSE, has urged employers to use World Mental Health Day to take the time to assess whether they are carrying out their legal duties and what they can do to prevent employees suffering from work-related stress.

She said: "We find many businesses focus on the 'nice to have' rather than making changes that will have a real impact. That means creating working conditions and an environment that prevents stress and supports good mental health – designing jobs with realistic workloads and targets, and encouraging people to have a healthy work-life balance.

"Prevention is better than cure – employers need to get proactive on reaching out and recognising the signs and causes of stress and bubbling issues in teams before they become problems. If you suspect you already have a problem, tackle it, it can be daunting but it's important to address the root cause.

"Failing to manage stress at work could lead to reduced productivity, sickness absence, or even losing a valued member of the team. Our Working Minds campaign has all the resources you need to make a change. You can get started in your own workplace, and you can share the resources to help others to thrive."

Launched in November 2021, Working Minds now has 35 partners, who have joined HSE's campaign urging workplaces to take action on work-related stress and mental health.

Working Minds helps employers to follow five simple steps based on risk assessment. They are to Reach out and have conversations, Recognise the signs and causes of stress, Respond to any risks you've identified, Reflect on actions you've agreed and taken, and make it Routine.

There are six main areas that can lead to work-related stress if they are not managed properly. These are: demands, control, support, relationships, role and change. Factors like skills and experience, age, or disability may all affect someone's ability to cope.

HSE has a free online learning tool for businesses with over 9,000 people already registered with over 90% saying it was easy to use and felt they could implement what they learned in their organisation.

Helpful resources:

- register for our free online learning
- download a risk assessment template
- see the Talking Toolkit for help structuring your conversations
- access resources to share with others

Notes to editors:

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. To read more about HSE's Working Minds campaign click here
3. For press and media enquiries please contact media.enquiries@hse.gov.uk

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Crown Censure issued following death of soldier

The Health and Safety Executive (HSE) has on, Thursday 3 October, issued the Ministry of Defence (MoD) with a Crown Censure following the death of a reservist soldier in Yorkshire.

Staff Sergeant John McKelvie of Drongan in Ayr, was killed after the Jackal vehicle he was driving rolled multiple times down a steep hill at Catterick Training Area on 29 January 2019.

At the time of the incident, the 51-year-old had been taking part in Jackal driver training with five other Army reservists. The off-road aspect of the training included a number of ascents and descents of steep inclines either side of a valley on land known as 'The Land of Nod'. It was when attempting one of these ascents that the Jackal lost traction and rolled backwards, throwing one of the course leaders from the vehicle as it did so. Staff Sergeant McKelvie remained in the vehicle suffering serious injuries as it rolled. Despite being airlifted to hospital, he died six days later.


Staff Sergeant John McKelvie

John’s sister Jacqueline Welsh (pictured below), provided a statement on behalf of the family, which said:

“John was a very outgoing person who loved spending time with his family.

“He was always there for you whenever you needed him.

“He loved his motorbike, and he loved sport and the outdoors. He was full of action!”


John with his sisters Jacqueline Welsh (left) and Cheryl Scott (right)

An investigation by the HSE identified that the training course involved hazardous activities, which gave rise to the potential for the vehicle to roll. This meant those taking part in the training were exposed to risk – however, that did not mean the activity itself should not have taken place. There were other steps that should have been taken to control the dangers with driving the vehicles, however these were not undertaken.

It also found a failure in oversight, meaning the course programme devised

progressed too quickly and prevented trainees from developing the necessary expertise and skills before attempting more challenging obstacles on the off-road element of the course.

The risk assessments were not suitable and sufficient, and despite numerous previous ‘rollover events’, the Army failed to foresee what could go wrong.

The investigation also found that standing orders and directions had not been properly followed.

HSE inspector Mark Slater said: “All training, including that which is required to be as realistic as possible, should be planned, risk assessed and executed in such a manner that it does not endanger those who are involved.

“Had the systems implemented by the Army been more robust, Sergeant McKelvie would probably still be alive today.”

This HSE Crown Censure was brought by HSE enforcement lawyer Nathan Cook and supported by HSE paralegal officer Rebecca Forman.

Notes to Editors:

1. The Health and safety Executive (HSE) is Britain’s national regulator for workplace health and safety. **hse.gov.uk**
2. 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.
3. More information on Crown Censures can be found here: http://www.hse.gov.uk/enforce/enforcementguide/investigation/approving-enforcement.htm [1]
4. The Code for Crown Prosecutors [2] 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[3].
5. Following investigations by North Yorkshire Police and the Royal Military Police, the Health and Safety Executive (HSE) was handed primacy of the investigation in December 2020.
6. The Crown Censure was issued on 3 October 2024 during a meeting held at the Army HQ in Andover. General Sir Roly Walker formally accepted the Crown Censure from HSE on behalf of MoD (Army) and acknowledged the offences and deficiencies that led to the death of Staff Sergeant McKelvie.