Siemens fined £600,000 after employee left paralysed at site in Hull

- Employee suffered serious, life-changing injuries following incident at Siemens Gamesa site
- HSE investigation found serious failures in systems of work

Siemens Gamesa has been fined following an incident in which an employee suffered serious, life-changing injuries at a site in Hull.

On 18 July 2024, a 37-year-old woman was carrying out work as part of the construction of a wind turbine blade when a structure they were working on collapsed on top of them, leaving them paralysed from the waist down.

The task being undertaken at the time of the incident involved building the web section of the blade, a large internal structure running almost the full length of the blade to provide rigidity and prevent buckling in strong winds, functioning much like a spine.

The incident occurred at the pre-cast section of the web, which sits at the root end of the blade where it connects to the rotor. This section weighs approximately 800kg before additional materials are added during the build process.

As the injured employee and a colleague were preparing the pre-cast section to be wrapped in materials, it fell towards them after support poles, which had been holding the structure in place, were removed.

An HSE investigation found that the company failed to adequately assess the risks arising from the work; failed to devise and implement a robust safe system of work to prevent employees from removing the support poles; and failed to adequately train employees in safe working methods. As a result, employees adopted unsafe practices to complete the task.

Following the incident, the company implemented a system whereby support poles are locked in place and can only be unlocked by a nominated person holding the key, once the relevant stage of the build has been completed.

Employers are required by law to protect your employees, and others, from harm. Assessing risk is just one part of the overall process used to control risks in your workplace. Extensive guidance on managing risks and risk assessment at work is available on the HSE website.

Siemens Gamesa Renewable Energy Ltd pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £600,000 and ordered to pay £7980.80 in costs at Grimsby Magistrates' Court on 22 May 2026.

HSE Inspector Mark Slater said: *"All work activities that carry a risk to health and safety must be properly risk assessed, and safe systems of work*

must be devised and implemented. Where protective measures are provided to prevent catastrophic incidents in high-risk areas, secondary measures such as lock-off procedures should also be in place.

"In this case, inadequate risk assessment and inadequate systems of work left employees to adopt their own working methods, exposing them to an unacceptable level of risk. This was a wholly avoidable incident."

The prosecution was brought by HSE enforcement lawyer Nathan Cook and paralegal officer Henrietta Ruthven.

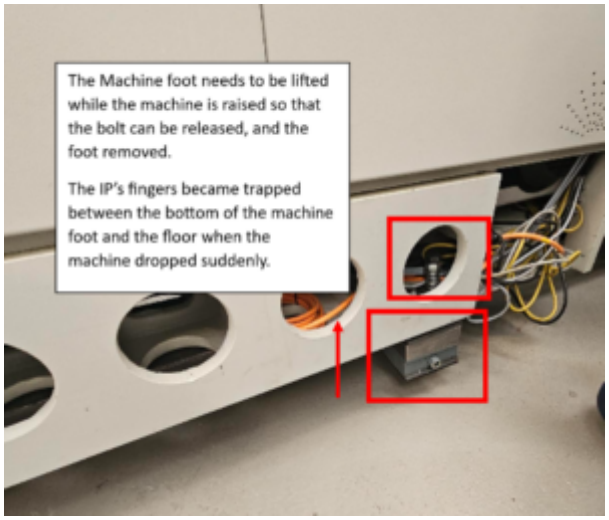
Further Information

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. Relevant guidance can be found here: managing risks and risk assessment at work: Overview – HSE
5. 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 Scotland can be found here.

Machine manufacturing company fined after employee's fingers crushed during lifting operation

- Employee suffered serious injuries after hand became trapped beneath three-tonne machine during lifting operation.
- HSE investigation found lifting operation had not been properly planned or carried out safely.
- Worker later underwent surgery to amputate two damaged fingers.

A machine manufacturing company in Shepshed, Leicestershire has been fined £170,000 after an employee's fingers were crushed when his hand became trapped beneath a machine during a lifting operation.



An experienced machine tool fitter was working for Winbro Group Technologies Ltd at its manufacturing site in Shepshed on 17 January 2024 when his right hand became trapped beneath the foot of a three-tonne machine during a lifting operation involving a forklift truck.

The worker's hand was underneath the machine when an unintended action caused the forklift truck's forks to drop to the floor. The machine was lifted to release his hand and, following medical treatment, two of the worker's damaged fingers were amputated in hospital.

An investigation by the Health and Safety Executive (HSE) found that Winbro Group Technologies Ltd had failed to ensure the lifting operation involving the forklift truck was properly planned and carried out in a safe manner.

HSE guidance states that where it is not reasonably practicable to avoid people working beneath suspended loads, employers should establish safe systems of work to minimise the risk. This includes ensuring loads are properly secured. Further guidance can be found here: Planning and organising lifting operations – HSE.

Winbro Group Technologies Ltd, of Illuma House, Unit 1, Gelders Hall Road, Shepshed, Leicestershire, pleaded guilty to breaching Regulation 8(1) of the Lifting Operations and Lifting Equipment Regulations 1998. The company was fined £170,000 and ordered to pay full prosecution costs of £7,999, along with a victim surcharge of £2,000, at Leicester Magistrates' Court on 12 May 2026.

HSE Inspector Rebecca Whiley said:

"Every year, a significant proportion of accidents, many of them serious and sometimes fatal, occur as a result of poorly planned lifting operations.

"This was a wholly avoidable incident caused by a lack of planning. HSE will not hesitate to take action against dutyholders who fail to do all that they should to keep people safe."

This HSE prosecution was brought by enforcement lawyer Neenu Bains and paralegal officer Hannah Snelling.

Further information:

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Public notice of an appeal

Public Notice of an appeal by Faldingworth Defence Limited against the imposed variation of their explosives licence by the Health and Safety Executive

- **Appellant Name:** Faldingworth Defence Limited (FDL)
- **Site Location:** Faldingworth Base, Spridlington Road LN8 3SQ.
- **Original Decision Authority/Respondent:** The Health and Safety Executive (HSE)
- **Nature of the Appeal:** FDL is appealing to the Secretary of State for Work and Pensions against the HSE's decision to impose a variation on their explosives licence under the Explosives Regulations 2014.

The Secretary of State for Work and Pensions has appointed Andrew Kinnier KC to hear the appeal on his behalf and to make recommendations about the outcome of the appeal so that he can make a determination in due course.

- **Grounds for Appeal:** The grounds of the appeal are as follows:

1. That the HSE has failed to identify any change in circumstances on the Faldingworth site since the issue of Exemption Certificates and Explosives Licences to tenants on the site that has resulted in the health and safety of those working there being prejudiced.
2. That there has been no material change in site circumstances and therefore Regulation 16(1)(a) is not applicable.
3. That a number of the changes proposed by HSE are outside the provisions of Regulation 16(1)(a).
4. That HSE has failed to give appropriate consideration to representations made under Regulation 16(5).
5. That HSE is acting contrary to the Explosives Regulations in the

enforcement of separation distances.
6. That HSE failed to consult on reasonable alternatives to the variation proposed.
7. The action taken is disproportionate and unnecessary.

- **Date of Hearing:** This appeal will be heard in person at Henderson Chambers, 2 Harcourt Buildings, Temple, London EC4Y 9DB on 15 and 16 June 2026
- **Persons wishing to attend or be heard:** Persons wishing to attend the appeal or to apply to be heard at the appeal shall inform the Health and Safety Executive **by 5th June 2026**, either by emailing Explosives.Licencing@hse.gov.uk or by writing to:

Explosives licensing

1.2 Redgrave Court

Merton Road

Bootle

L20 7HS

Any persons applying to be heard must also serve on HSE a statement of their proposed submissions **by 5 June 2026**, which will then be shared with the Appellant and the Secretary of State's Appointed Person. The Secretary of State's Appointed Person will then decide the application to be heard.

Glasgow company fined £129,000 after worker lost fingers in machinery incident

- Worker has three fingers partially severed after contact with moving machinery at Glasgow fuel plant
- Radio miscommunication led to worker believing high-spinning blades had been turned off
- HSE investigation found the company failed to prevent access to dangerous parts of machinery

A biomass company in Glasgow has been fined a six-figure sum after a worker lost parts of three fingers in machinery at the Daldowie Fuel Plant.

The incident happened at SMW Limited's site in Uddingston, near Glasgow, in 2023.

A shift operator with 17 years’ experience at the plant, suffered his injuries on 8 June 2023 while attempting to clear a blockage on a surge hopper – a large vessel through which processed material passes at the end of the production line.

The 57-year-old employee had been clearing a blockage in a rotary lock valve which contained rotating blades that turn at 25rpm. As he attempted to clear the blockage, he removed a metal clip and rubber gaiter to gain access to the valve. Communication with the control room, which operated the valve remotely, was carried out by hand-held radio. There was no line of sight between the two areas, and the radios were subject to interference.

A miscommunication over the radio led the employee to believe that the rotary lock valve had been turned off. Believing it was safe to do so, he inserted his right hand into the hopper, where it came into contact with the moving blades. The index, middle and ring fingers of his right hand were all partially severed, and he has not returned to work since the incident.

The surge hopper onsite

An investigation by the Health and Safety Executive (HSE) found that while the company had a specific safe system of work in place for clearing blockages on surge hopper rotary lock valves – which the man had been trained

on as recently as April 2023 – they had failed to ensure that access to the dangerous parts of the machinery was prevented.

HSE provides detailed guidance on safeguarding machinery and preventing access to dangerous parts, including under the Provision and Use of Work Equipment Regulations 1998 (PUWER). PUWER places duties on people and companies who own, operate or have control over work equipment. PUWER also places responsibilities on businesses and organisations whose employees use work equipment, whether owned by them or not. Further information on PUWER is available at the HSE website

SMW Limited pleaded guilty to breaching The Provision and Use of Work Equipment Regulations 1998, Regulations 11(1) and (2) and the Health and Safety at Work etc. Act 1974, Section 33(1)(c) at Hamilton Sheriff Court on 20 May 2026. The company was fined £120,000 and ordered to pay a Victim Surcharge of £9,000.

HSE inspector Nicola Kerr said:

“This man’s injuries had had a profound impact on his life, and were completely preventable.

“Where workers are required to interact with machinery containing dangerous moving parts, employers must ensure that adequate physical safeguards are in place to prevent access to those parts.

“Relying solely on radio communication to control isolation – particularly where there is no line of sight and interference is possible – is simply not good enough.

“A fixed guard would have been a reasonably practicable measure that could have prevented this incident entirely.”

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. Relevant guidance can be found here Provision and Use of Work Equipment Regulations 1998 (PUWER) – overview – HSE.
5. 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 Scotland can be found here.

Offshore firm fined following death of worker on Valaris 121 whose body was never recovered

- HSE investigators uncovered what happened to Jason Thomas, who went missing at 4pm on 22 January 2023.
- Fellow workers on the Valaris 121 offshore rig heard a loud noise and when searching for Mr Thomas found his hard hat, gloves and radio near the airlock door.
- HSE investigation concluded Mr Thomas had plunged into North Sea after falling through a grate which had not been properly secured.

An offshore firm has been handed a £267,000 fine after a long-running HSE investigation found that crewman Jason Thomas was killed when he fell through a missing deck grate and was lost to the North Sea.

Ensco Offshore UK Limited (EO UK Ltd) was responsible for the operation of the Valaris 121 installation when the incident occurred on 22 January 2023.

Jason Thomas, 50, from South Wales, was an experienced offshore worker with around 16 years in the industry. At the time of his death, he was employed by Ensco Services Limited, a wholly owned company of EO UK Ltd, where he had progressed from roustabout to deck foreman and then crane operator.

The incident aboard Valaris 121 when it was under tow

After he went missing on 22 January 2023, an HM coastguard search was launched and called off the following day, though Jason's body was never recovered. HSE carried out a full investigation to find out what happened.

HSE's findings: how the incident unfolded

A thorough investigation by the Health and Safety Executive (HSE) found that the grating panel had not been secured in line with the original equipment manufacturer's (OEM) specifications, and that later inspections had not checked the deployment of Hilti clips, which are used to secure gratings to their substructures and stop them coming loose

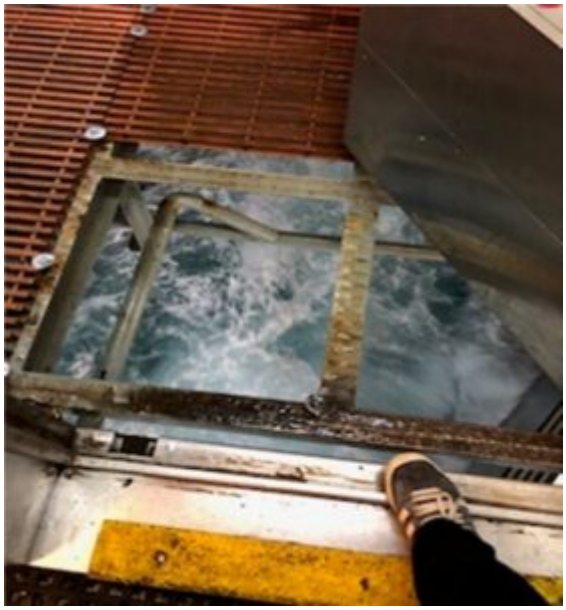
On the morning of 22 January, the rig's hull was afloat and under tow towards Dundee for maintenance. As the day progressed, weather conditions deteriorated significantly, with windspeeds exceeding 30 miles per hour and wave heights well above five metres.

Mr Thomas, who was supervising the deck team during his shift, completed water integrity checks with a colleague at around 2pm. Both men had taken water over their boots during the checks. Mr Thomas was observed removing his coveralls and leaving his hard hat and gloves near the airlock door before changing into training shoes.

At approximately 2.30pm, he was seen taking a break in one of the staff lounges. Around 15 minutes later, a mechanic entered carrying a lifebuoy that had become detached from its holder on the main deck. Mr Thomas told him to leave it in the lounge and that he would 'deal with it'. He was last seen at around 3.05pm leaving the lounge with a cup of coffee and his mobile phone.

At around 4pm, a colleague in the boot room heard a loud noise from outside. On opening the door to deck 1, he found that the grating immediately outside had been displaced, leaving a void above the waters of the North Sea. The control room was alerted immediately, but repeated tannoy calls failed to locate Mr Thomas. HM Coastguard was eventually contacted several hours later,

shortly before 9pm.


The missing grate was directly in front of the door to the deck

During the subsequent search of the rig, Mr Thomas’s hard hat, gloves and radio were found near the airlock door. His coveralls were never recovered. A search and rescue operation was launched under the direction of HM Coastguard but was called off the following day.

Mr Thomas’s mother subsequently obtained a Presumed Death Certificate through the Welsh Courts, confirming that he died on 22 January 2023. She passed away shortly after receiving this confirmation.

The HSE investigation further concluded that wave action over the course of the afternoon had applied sufficient upward force to the grating to cause the fixings to fail and displace it. The possibility of malicious interference was considered but ruled out following examination at HSE’s Buxton scientific facility, where no tool marks were found on the fixings or clips.

Following the incident, the company replaced all polymer grating across its fleet with galvanised steel grating.


Valaris 121 was being taken back to Dundee

Ensco Offshore UK Limited pleaded guilty to breaching Section 3(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. At Aberdeen

Sheriff's Court on 18 May 2026, the company was fined £267,000 with an added victim surcharge of £20,025 also imposed taking the total payable to £287,025.

HSE principal inspector Steven Hanson Hall said:

"This was a profound tragedy which left lasting mark on Jason's colleagues and his community.

"Jason Thomas was an experienced offshore worker who lost his life in the most unimaginable way possible. The fact his body was never found resulted in great anguish to his mother, who has also since died.

"The investigation was incredibly complex and thorough and we hope it has provided Mr Thomas' remaining family with some closure and reassurance that we did everything we could to secure them justice.

"Grating systems must be designed, installed and maintained so that they do not present a risk to anyone that may use them, particularly when used in environments where they are susceptible to damage.

"Had the company taken relatively simple measures to identify and control the underling risks, particularly during the rig move, it is highly likely the incident would never have occurred, and Jason would have returned home."

Ensco Offshore UK Limited pleaded guilty to breaching Section 3(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined at Aberdeen Sheriff's Court on 18 May 2026.

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