Council fined after failures led to care home death

- Man was able to leave care home undetected in early hours of morning.
- Search involved police, coastguard and firefighters.
- Doors at the home were not alarmed or protected.

A local authority has been fined after the death of a patient who went missing from a care home on the Isle of Barra.

Western Isles Council pled guilty to a charge under the Health and Safety at Work Act following the death of a 69-year-old man at St Brendan's Care Home in Castlebay.

Allan MacLeod, who had been diagnosed with Dementia, had been a resident at the home – one of five operated by the council throughout the Western Isles – for around six months at the time of his death. In the early hours of 9 March 2024, he had been able to leave his bedroom without the knowledge of staff and was only found around four hours after going missing. He died a short time later in hospital.

Mr MacLeodhad been placed in the home in October 2023 to allow him to be nearer a relative who stayed on Barra. In his first month at the home, staff observed him and determined patterns in his behaviour and how they could best assist him. He was able to go on regular road trips around the island with his family.

On 8 March, having been settled in bed around 9pm, hourly checks were carried out to ensure his wellbeing, but at 2am on 9 March, his bed was unoccupied, and he could not be accounted for after a search of the home.

To avoid being observed by staff, he had exited the home via the only door that was not alarmed and was ten metres from his bedroom. Police Scotland were alerted and a search initiated.

Local Coastguard, RNLI and firefighters were called out to assist in the search and at around 6am, the Coastguard helicopter detected a heat signature near the home on the patio of a residential property.

Mr MacLeod was found with facial injuries consistent with falling. He was transferred to hospital, but despite the efforts of medical staff, he died an hour later.

An investigation by the Health and Safety Executive (HSE) determined that he had made several previous attempts to leave the home. Any measures that staff had taken to mitigate this, by fitting an electronic tag to his clothing that indicated his whereabouts had been defeated by Mr Macleod having removed it.

A risk assessment carried out in December 2023 indicated that Mr MacLeod would remove a tag if he located it, therefore staff required to be vigilant

to this behaviour. It was only after his death that the home introduced a regime of half hourly checks on residents. Arrangements had already been made to install keypad entry systems on all doors, but this work had not been completed before Mr MacLeod's death.

Western Isles Council, of Sandwick Road, Stornoway, pleaded guilty to breaching Sections 31 and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The council was fined £80,000 at Lochmaddy Sheriff Court on 6 August 2025.

HSE inspector Ashley Fallis said: "This was a tragic and preventable death.

"The council should have made sure the home had stronger measures in place with Mr MacLeod's risks already known and assessed.

"Although changes have since been made, they came too late to prevent his death."

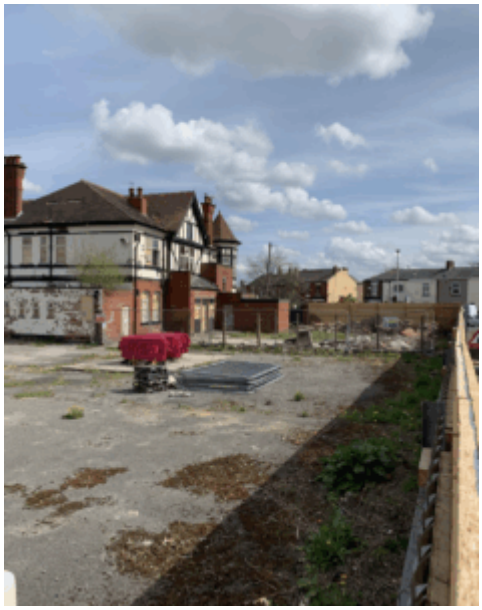
Further information:

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 Scotland can be found here.

Manchester firm fined after workers exposed to asbestos risks

A Manchester-based construction company has been fined after workers were put at risk of exposure to asbestos.

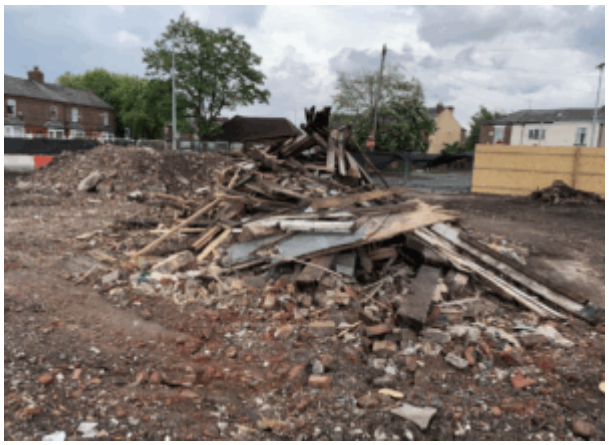
A1 Property Maintenance Management Limited was acting as the principal contractor during work at the former Unicorn Public House on Liverpool Road, Eccles, Greater Manchester.


The Unicorn Pub

During a routine inspection to the site on 16th May 2022, a Health and Safety Executive (HSE) inspector discovered that 12 square metres of asbestos insulation board (AIB) had been present in a dumb waiter lift shaft – but had already been illegally removed by unknown individuals. This led to the inspector issuing a prohibition notice stopping all work on site until an asbestos survey had been completed.

Previously, after noticing the pub door had been broken into, a site worker had entered the building, where they discovered what appeared to be asbestos debris in the area around the lift shaft. The debris was later wrapped and removed by a licensed asbestos removal contractor.

However, A1 Property Maintenance Management Limited failed to carry out a full asbestos survey to confirm that all asbestos-containing materials had been removed before allowing further construction work to take place.


Property demolition site of former pub

HSE's has two campaigns "Asbestos and You" and "Asbestos Your Duty" reminding tradespeople about the dangers of asbestos and the importance of working safely with it, also to reach those responsible for the maintenance and repair of non-domestic buildings.

The regulator also provides comprehensive guidance for workers and employers about working safely with asbestos on its website. This includes information on how to identify asbestos, what to do if you find it, and the appropriate safety measures needed when working with or around asbestos-containing materials. Workers in trades such as construction, maintenance, demolition and installation are particularly at risk and should ensure they have appropriate training before starting work that might disturb asbestos.

The company pleaded guilty to breaching Regulation 4(6) of The Control of Asbestos Regulations 2012. It was fined £5,360 and ordered to pay £5,117 in costs at a hearing at Tameside Magistrates' Court on 30 July 2025.

Speaking after the hearing, a HSE spokesperson said:
"This was a serious incident and put those working in the building at risk of being exposed to the harmful effects of asbestos.
"Duty holders are reminded of the need to review without delay an asbestos assessment if there has been a significant change in the premises to which the assessment relates."

The prosecution was supported by HSE enforcement lawyer Sam Crockett and paralegal Hannah Snelling.

Further information:

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: hse.gov.uk
4. Guidance for working safely with vehicles can be found at: Workplace transport – HSE
5. HSE Asbestos guidance can be found here: https://www.hse.gov.uk/asbestos/

Sole trader fined after worker suffered serious injuries

- Man fell from height due to lack of edge protection.
- Second time HSE action against sole trader.
- HSE guidance on working safely at height is available.

A worker suffered serious injuries after falling from a flat roof that did

not have any edge protection.

A sole trader has been fined following a prosecution by the Health and Safety Executive (HSE).

It was the second time Gary Smith, trading as GJ Smith Roofing, had failed to provide edge protection on a job, with HSE previously taking enforcement action against him.

Smith pleaded guilty following the incident on 15 December 2022, when a team of roofers and labourers were working on his behalf, replacing a flat roof on a house in the Luton area.

A worker suffered serious injuries after falling from a flat roof that did not have any edge protection

At around 11am, one of the workers was carrying large wooden boards across the roof, when he inadvertently stepped off the edge of the roof falling a distance of about 10 feet. He suffered a fractured vertebrate in his back and a broken ankle.

Working at height remains one of the leading causes of workplace injury and death and HSE has detailed guidance on working safely at height.

The HSE investigation found the task had not been properly risk assessed and planned which meant that edge protection around the flat roof had not been put in place, despite it being reasonably practicable to do so. Following HSE intervention, edge protection was installed before work re-commenced.

Gary Smith of Watling Street, Dunstable, pleaded guilty to a breach of Regulation 4(1) of the Work At Height Regulations 2005. He was fined £2,125 and ordered to pay costs of £5,445 at a hearing at Luton & South Bedfordshire Magistrates' Court on 29 July 2025.

Speaking after the hearing, HSE inspector Tim Nicholson said: "Clearly Mr Smith hadn't learnt from his previous failures.

"Sadly, this latest offence resulted in a man being seriously injured.

"What makes this incident even more frustrating is the fact it could so easily have been avoided by properly planning the task and ensuring that

suitable edge protection had been put in place prior to work starting."

This HSE prosecution was brought by enforcement lawyer Julian Ward and paralegal officer Helen Hugo.

Further information:

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3. Further details on the latest HSE news releases is available.
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5. HSE guidance about working safely on roofs is available.

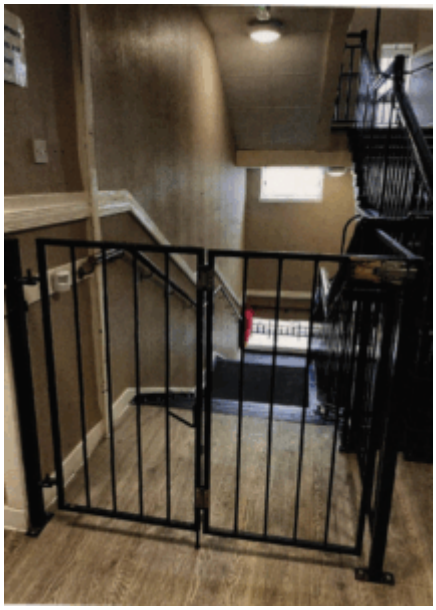
Glasgow care home provider fined after death of patient

- Vulnerable man walked more than 300 steps from his room to a carpark.
- Care home staff did not notice he had left and falsified records.
- HSE guidance is available on vulnerable residents

A care home provider has been fined more than £50,000 after an elderly patient died in the early hours of Boxing Day in 2022.

Hugh Kearins, 77, had managed to leave the Chester Park Care Home in Glasgow via a series of stairways and fire doors. An inspector from the Health and Safety Executive (HSE) counted 320 steps from the Mr Kearins room to the care home's car park just off Lambhill Street, where his body was found at around 7am.

Mr Kearins, who had dementia, had been living in a room within the Clyde Unit of the home since 2012. As part of its investigation, HSE made enquiries regarding the use of an internal fire door and was unable to obtain corroborated evidence of who was last to use the door prior to Mr Kearins, who is thought to have exited through it just before 1am. The same door was closed about an hour later by an unknown member of staff carrying out routine checks.

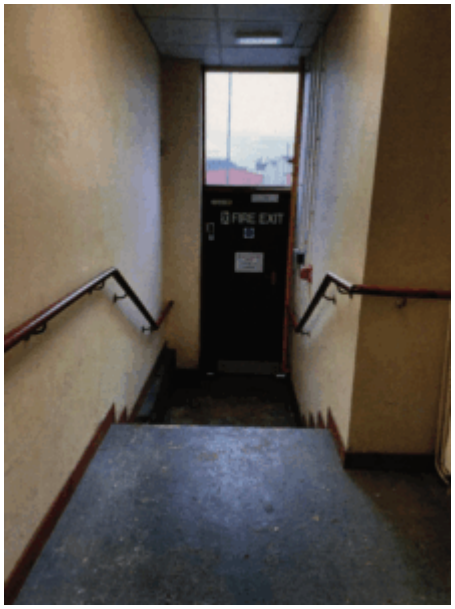


A HSE inspector counted 320 steps from Mr Kearins' room to where his body was found

It was confirmed by the care home manager that once the door was noted to be insecure, the member of staff should have initiated a head count of all of the residents to ensure their safety. However, this was not carried out.

The HSE investigation found the company had failed to have a safe system of work in place. Records held by the company in relation to Mr Kearins, extensively noted the clear risk that he might abscond or 'wander'. It was part of his care plan that he be checked or monitored every hour.

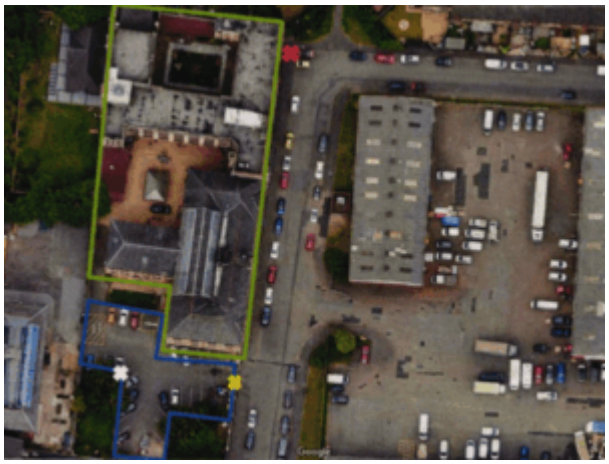
HSE guidance acknowledges that vulnerable people can enjoy the outdoors. However, it also states that, "you should consider ways of managing the risks to vulnerable people so they can still enjoy the outdoor environment".



He managed to leave the building through a fire door

A senior care assistant and a care assistant who had responsibility for Mr Kearins' care were also found to have falsified records, stating that they had performed tasks involving him at a time when he was in fact no longer in

the home. Both were unaware he was no longer in his room until news of his death became known following the discovery of his body in the car park.



The red cross indicates where Mr Kearins' exited the home, with the white cross showing where his body was found the next morning

The management failures in respect of the alarm door reactivation were not causative of Mr Kearins' death and would likely not have even come to light but for four individual errors:

- The unidentified member of staff who closed the internal fire door without further action;
- The fire alarm for the internal fire door which had been deactivated
- The unidentified member of staff who left the unalarmed external fire door insecure; and
- The actions of both the senior care assistant and the care assistant.

Oakminster Healthcare Limited, of Lambhill Street, Glasgow, pleaded guilty to breaching Sections 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined £53,750.

HM Inspector Amna Shah said: "This incident was completely avoidable.

"It is hugely concerning that a vulnerable man was able to walk so far and through so many doors without being noticed."

"We counted he had walked more than 300 steps."

"The fact this incident happened at Christmas time makes it all the more tragic."

"We will always take action against those who fail in their responsibilities."

Further information:

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5. HSE guidance about health and safety in care homes is available.
6. Both carers were subsequently dismissed from their employment following disciplinary interviews a few days later. They are now subject to investigation by the Scottish Social Services Council.

TATA Steel fined £1.5 million after father-of-three crushed to death at Port Talbot plant

- Grandfather Justin Day would have turned 50 this year
- Family says their world has been "shattered"
- HSE guidance on safe use of equipment is available

Tata Steel has been fined £1.5 million following the death of a contractor at its Port Talbot steelworks plant.

Justin Day's family learnt of his death while they were waiting for him at his youngest son's school rugby match.

The much-loved father-of-three and grandfather was working at the steel manufacturer's site in South Wales when he was crushed to death by a piece of machinery on 25 September 2019.

Maintenance work to replace a lift cylinder on a large conveyor system had been completed earlier that day, and the system was in the process of being put back into service when a hydraulic leak was found. A radio call was sent out for Justin, 44, to resolve the issue at about 2pm.

Although power was isolated to part of the system, other sections remained live. As staff worked on the lower level to fix the leak, Justin returned to the floor above and climbed into the conveyor system. His presence triggered sensors that activated a moving beam in a live section, fatally injuring him. He was sadly pronounced dead at the scene.

Tata Steel failed to ensure the conveyor system was properly isolated and guarded. The company did not take sufficient steps to manage the safety of the ongoing work.

The Health and Safety Executive (HSE) investigated Justin's death and brought

a prosecution against Tata for what an inspector described as “basic” health and safety failures.

At the time Tata’s Port Talbot plant was the largest steelworks in the UK. Earlier this month, construction started on Tata’s electric arc furnace (EAF) at the same site.

Justin Day’s family had been waiting for him at the rugby field that afternoon, ready to watch his youngest son play in a school match. But instead, they received a devastating phone call telling them he had been involved in an accident. Just an hour later, they learned he had been killed.

Justin would have turned 50 this year. His wife Zoe Day said rugby was his passion, and that when his sons played, he was their “biggest fan”. She “never imagined” to be given the news of the incident while waiting for him to arrive pitch side.

“Since losing Justin I am not the same person I was,” she said. “I have struggled since that day – mentally, I am lost and don’t know where I’m going with life. It’s shattered my whole world.

“We were together for 23 years and did everything together. I can’t put into words how much this has affected me. I am a shadow of my former self and from the day of the incident, my world fell apart.”

The HSE investigation into the incident found Tata Steel failed to ensure the work to replace the lift cylinder was done safely. After the job was completed, the company also failed to properly isolate the conveyor system before Justin returned to address the leak.

Tata Steel also failed to ensure the conveyor system was effectively guarded to prevent access to dangerous moving parts of the machinery.

Tata Steel (UK) Ltd, of Grosvenor Place, London, pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. The company was fined £1.5 million and ordered to pay £26,318.67 in costs at Swansea Crown Court on 31st July 2025.

HSE inspector Gethyn Jones said: “Justin Day’s death could so easily have been prevented. A much-loved family man is not here because of failures in health and safety basics.

“Employers have a responsibility to make sure sufficient procedures are in place to protect workers – both employees and contractors – and that those procedures are understood and followed.

“The dangers of moving machinery are well known. Sufficient risk assessments must be carried out and access to dangerous areas must be properly guarded and controlled.

“This has been a long and thorough investigation, and we believe this is the right outcome. It is clear that Justin’s death has had a devastating impact on his family, his friends and the wider community. Our thoughts remain with

them.”

HSE guidance on the safe use of work equipment is available on our website: Safe use of work equipment – HSE

This prosecution was brought by senior enforcement lawyer Jon Mack at HSE.