Care home fined after resident choked to death on meal

- Resident died after being served food that did not meet his documented swallowing requirements.
- HSE investigation found a failure in the system of work for preparing and serving modified meals.
- Thomas Telford had a well-documented history of dysphagia and was at high risk of choking.

A care home company has been fined after a resident choked to death on food that had not been prepared in accordance with his dietary requirements at a Selkirk care home.

Selkirk Sheriff Court heard that on 25 May 2023, Thomas Telford, known as Barry, aged 86, choked during lunch at Riverside Healthcare Centre, Bridge Street, Selkirk. Mr Telford had been a resident at the home since 9 May 2023, having been admitted directly from Kelso Community Hospital.

He had a complex medical and a well-documented history of dysphagia – difficulty swallowing – that had been identified as far back as November 2019.

Mr Telford had been assessed as requiring a Level 5 (minced and moist) diet under the International Dysphagia Diet Standardisation Initiative (IDDSI), meaning all food should be minced into small moist pieces no greater than 15mm in length and 4mm wide. His care plan also required that he be supervised at mealtimes due to his tendency to overfill his mouth and eat quickly, and he had been identified as being at high risk of choking.

At lunchtime on 25 May 2023, Mr Telford was served a meal of beef, mashed potato and cabbage. The beef served to him had not been prepared in accordance with his Level 5 dietary requirements. A carer supervising the dining room noticed his lips turning blue and immediately raised the alarm. Backslaps and abdominal thrusts were administered, and an ambulance was called. He was pronounced dead at Borders General Hospital at 14:00 hours.

An investigation by the Health and Safety Executive (HSE) found that Riverside Care Limited had failed to ensure a sufficiently robust system of work for the preparation and serving of texture-modified meals. Whilst the home operated a broadly suitable system of serving either normal or modified meals, and staff had received training on dysphagia and the IDDSI framework, that system had failed on the day in question. As a result, Mr Telford was served food that was not safe for him to consume.

Employers providing care to individuals with swallowing difficulties must ensure that systems for preparing and serving texture-modified diets are sufficiently robust to guarantee that only appropriate food is served to those who require it, at every mealtime without exception.

HSE provides extensive guidance intended to help those providing and managing care homes – to give them a better understanding of the real risks and how to manage them effectively.

On Tuesday 3 March 2026, Riverside Care Limited, of Bridge Street, Selkirk, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £16,000 at Selkirk Sheriff Court.

After the hearing, HSE Inspector Robbie Morrison, said:

"Mr Telford's need for a texture-modified diet was well documented and well known to those caring for him. He had a history of dysphagia and had been clearly identified as being at high risk of choking.

"Employers have a duty to ensure that the systems they put in place to protect the people in their care are robust enough to work consistently and without fail. In this case, that system was not sufficiently robust, and the consequences were fatal.

"This was a tragic and entirely preventable death. We hope this case serves as a reminder to all care providers of their responsibility to ensure that residents with complex dietary needs receive only food that is safe for them."

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. Guidance on health and safety in care homes can be found here: Health and safety in care homes – 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 can be found here.

Immingham metal fabrication company sentenced after seven workers develop vibration-related illnesses

- Seven employees reported with vibration-related conditions including

nerve damage and finger blanching
- Workers described daily life impacts including numbness at night and inability to grip
- Company failed to risk assess vibration exposure or provide health surveillance and training

A metal fabrication company based at Immingham Docks in North East Lincolnshire has been sentenced after pleading guilty to exposing multiple employees to vibration risks at work.

HSE became aware in June 2024 of three reports of vibration-related illness among employees of Drury Engineering Services Ltd. An investigation was opened and an Improvement Notice served on the company to control the ongoing risk.

The notice was served because the company had failed to reduce employees' vibration exposure to as low a level as reasonably practicable through organisational and technical measures.

During the investigation, inspectors identified a further three employees who met the threshold for reporting to HSE due to vibration-related illness. A seventh report was made by the company later that year.

Employees told inspectors the illness was affecting their daily lives. Some experienced finger blanching during simple household tasks such as mowing the lawn. Others were kept awake at night by numbness in their hands, while some described being unable to grip and suffering nerve damage.

Drury Engineering Services Ltd has been operating at Immingham Docks since 2000. A new health and safety manager was appointed in June 2022 and began work to address issues with the company's vibration management system, but by this point employees had already been significantly exposed to vibration risks.

The investigation found that the company had failed to:

– suitably and sufficiently assess the risks from vibration exposure

– implement organisational and technical measures to reduce vibration exposure to as low a level as reasonably practicable

– place employees who were exposed to significant levels of vibration under a suitable health surveillance system

– provide employees with suitable and sufficient information, instruction and training

HSE provides extensive guidance on the risk of vibration in the workplace and the need to ensure that the risk is properly assessed, and appropriate measures implemented to control exposure from the risk of vibration.

Drury Engineering Services Ltd, of East Riverside, Immingham Dock, Immingham, North East Lincolnshire, pleaded guilty to breaching Section 2(1) of the

Health and Safety at Work etc. Act 1974. The company was fined £44,000 and ordered to pay £8,061.70 in costs at Grimsby Magistrates' Court on 26 February 2026.

HSE Principal Inspector Chris Tilley said: "Today's fine should send a clear message that both HSE and the courts take seriously the failure to manage employees' exposure to vibration.

"HSE will not hesitate to take action against companies that do not do all they should to keep people healthy and safe."

This prosecution was brought by HSE enforcement lawyer Matthew Reynolds and paralegal officer Benjamin Stobbart.

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 & 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 are available.
4. Guidance on Vibration at Work can be found here: Vibration – 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 England can be found here and those for Scotland here.

Police force fined after student officer hit by car on Christmas Eve

- The student officer had been responding to a traffic collision.
- HSE investigation found West Mercia Police failed to manage risks.
- Force failed to provide suitable information and training to its officers.

A police force has been fined after one of its officers was hit by a passing car while responding to a traffic collision on Christmas Eve.

The 22-year-old was a student officer working for West Mercia Police when the incident happened on 24 December 2023. The officer had been responding to the traffic collision in Bridgnorth, Shropshire. That collision occurred on a single carriageway road that had no street lighting and where the national

speed limit for the road was 60 mph.

The officer had been stood on a bend, managing traffic at the scene when he was hit by a passing car. He sustained life-threatening and life-changing injuries.

An investigation by the Health and Safety Executive (HSE) found that West Mercia Police failed to do all that was reasonably practicable to manage the risks arising from or in connection with traffic collisions. The force's risk assessments were not suitable and sufficient and it failed to provide adequate equipment for safely responding to traffic collisions.

There was also a lack of suitable information, instruction and training for its officers. As a result, employees and members of the public were exposed to unnecessary risks.

In June 2021, the National Police Chiefs' Council (NPCC) sent all police forces across the UK a series of recommendation reports which provided relevant advice explaining how to implement road safety recommendations following an officer and staff safety review report.

The Office of Chief Constable West Mercia Police, Headquarters, Hindlip Hall, Hindlip, Worcester, pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. The force was fined £85,800 and ordered to pay £9,402 in costs at Birmingham Magistrates Court on 20 February 2026.

HSE Inspector Keeley Eves said:

"We recognise that police officers inevitably face significant and serious dangers as part of their normal work. The nature of policing is such that even where all reasonably practicable steps have been taken to minimise the risks, there may still be a significant risk to those engaged in such work.

"However, police officers should not be exposed to unnecessary risks while keeping the public safe.

"In this case, West Mercia Police failed to implement all reasonably practicable measures to minimise risks to its employees and members of the public in connection with road traffic collisions.

"Tragically, this resulted in a student police officer sustaining life changing injuries.

"After the incident, the force implemented significant changes, which included revisions to risk assessments, policies, procedures, equipment and training.

"These measures should have been in place prior to the incident."

This HSE prosecution was brought by enforcement lawyer Edward Parton and paralegal officer Lynne 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. 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 can be found here.

Forging company fined over death of employee entangled in lathe

– Nick Hardiman, 54, died after becoming entangled in a lathe while using handheld emery cloth at Somers Forge Limited in Halesowen on 8 December 2023

– HSE found the company failed to prohibit dangerous working practices, prevent access to moving machinery parts, and establish safe operating procedures

– HSE guidance states emery cloth should never be applied directly by hand

A Halesowen forge has been fined £750,000 after an employee sustained fatal injuries when he became entangled in a 20-metre long lathe.

Nick Hardiman was employed by Somers Forge Limited as a machinist at their forge on Prospect Road, Halesowen.

On 8 December 2023, the 54-year-old from Kidderminster was working on a lathe in the machine shop. Whilst using handheld emery cloth to finish a rotating component, Mr Hardiman became entangled in the dangerous moving parts of the lathe, sustaining catastrophic injuries.

Despite the efforts of emergency services, Nick Hardiman sadly died later that evening.


Nick Hardiman

Mr Hardiman leaves behind his partner, Melanie; his siblings Robert, Glenis, Lorraine and David; and his parents Michael and Doreen.

Nick's siblings Robert, Glenis, Lorraine and David said: "We can't comprehend how someone can go to work and not come home again. Everyone is absolutely devastated."

An investigation by the Health and Safety Executive (HSE) found that Somers Forge Limited had failed to:

– prohibit the use of handheld emery cloth on lathes

– prevent access to dangerous moving parts of the lathe

– ensure personal protective equipment (PPE) worn by workers did not create risk of being injured by, or drawn into, the lathe

– undertake a suitable and sufficient risk assessment for the lathe, or establish a safe operating procedure

HSE provides guidance on using emery cloth on metalworking lathes. This guidance establishes that it is never acceptable to apply emery cloth by hand to a rotating component, as there is a risk of the operator becoming entangled or dragged into the danger zone.


Somers Forge Ltd

Somers Forge Limited pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. The company was fined £750,000 and ordered to pay £38,314 in costs at Walsall Magistrates' Court on 18 February 2026.

Nick's partner Melanie said: "Nick had everything to live for – a loving home and a partner who adored him, family and friends, and a fulfilling life ahead of him. We used to have a life; now I just exist.

I will forever miss the sound of his voice, the smell of his aftershave, the feel of his cuddles and kisses, and the times we would spend together."

Nick's father Michael said: "We feel very proud when we speak about Nick, but it really hurts to talk. We think about Nick every single day."

HSE Inspector Sophie Neale said: "This was an entirely preventable incident which has had tragic consequences.

Employers must ensure that safe systems of work are in place and that workers are not exposed to foreseeable risks from dangerous machinery.

My thoughts are with Nick's family and friends."

This prosecution was brought by HSE enforcement lawyer Chloe Ward, and paralegal officer Stephen Grabe.

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 are available.

4. Relevant guidance can be found here Using emery cloth on metalworking lathes – 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 can be found here.

Grounds maintenance company fined

after employee killed operating ride-on lawnmower

- Worker was killed when the ride-on mower he was operating ended up in village pond.
- HSE investigation found no suitable site-specific risk assessment had been carried out.
- Safety-critical roll-over protection system had been removed from the machine.

A grounds maintenance company has been fined after an employee was killed while operating a ride-on lawnmower near Ripon.


the lawnmower involved

Kamil Grygieniec, 23, from Northallerton, was cutting grass around a village pond in North Stainley on 8 October 2021 when the ride-on mower he was operating descended a steep incline and ended up in it.

The mower was being used without a safety-critical roll-over protection system (ROPS) fitted.

An investigation by the Health and Safety Executive (HSE) found that MHS Countryside Management Limited had failed to carry out a suitable and sufficient site-specific risk assessment for the work being undertaken.

The investigation also established that the mower’s roll-over protection system (ROPS) had been removed at some point prior to the work taking place. ROPS are designed to protect operators in the event of a machine overturning and are a critical safety feature when working on uneven or sloping ground.


where the incident took place

Suitable risk assessment is essential when operating ride-on machinery, particularly where there is a risk of overturning on slopes or near water. Employers must ensure equipment is appropriate for the terrain and fitted with necessary safety features to protect operators. Find out more on our website here Risk assessment: Template and examples – HSE.

MHS Countryside Management Limited, of Bishop Auckland, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £27,000 and ordered to pay £11,166 in costs at York Magistrates' Court on the 17 February 2026.

Family tributes

Kamil's mother and father said:

"The pain I feel every day since that tragedy is unimaginable, I do not wish that on anybody. That day I lost part of me.

"I will never be able to hug him, tell him how much I love him. I will never receive flowers from him, will never meet him wife or his children. Kamil was my physical and mental support.

"That day was his last day at that workplace and it happened to be the last day of his short life."

"I don't know what life holds for the future for me, but what I am certain of is it will not be as full or as happy now that Kamil has gone from our lives.

"What makes it even worse, I believe his death could have been prevented and should never have happened."

After the hearing, HSE Inspector Darian Dundas said:

"This is a profoundly tragic case which is made all the more harrowing because the safety feature designed to prevent incidents like this had been removed from the lawnmower – leading to the fatal turn of events which has robbed a family of their loved one.

"The completion of a suitable and sufficient site-specific risk assessment is vital before undertaking work activities and ensures appropriate action can

be taken to eliminate hazards or, where this is not possible, to properly control the risks.

“In this case, the failure to assess the risks and ensure suitable safety measures were in place resulted in a tragic and entirely avoidable loss of life.”

This prosecution was brought by HSE enforcement lawyer Iain Jordan and supported by paralegal officer Stephen Grabe.

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 Risk assessment: Template and examples – 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 can be found here.