

# Stay safe around cattle in the countryside at Easter

The Easter break will see thousands of people heading into the countryside to stretch their legs and enjoy Britain's stunning scenery.

While the vast majority of walkers enjoy the countryside safely and use the extensive network of footpaths, bridleways, and public access land without any problems, going through fields where there are cattle can be hazardous.

Britain's workplace regulator, the Health and Safety Executive (HSE), is reminding both farmers and walkers to do all they can to help to keep everyone safe, particularly where cattle and countryside visitors are close together.



Injury by animal was the leading cause of death on British farms last year

HSE is currently running its [Your Farm, Your Future campaign](#) aimed at improving safety on British farms with a focus on livestock in 2024. The safety of farmers themselves from cattle is a concern to the regulator all-year round; statistics show four workers were killed following incidents with animals on farms in 2022/23.

HSE regularly investigates incidents involving cattle and the public. A proportion of these incidents involve serious injury and sometimes death. On average, between one and two members of the public are killed each year while using public rights of way, others suffer serious injury.

In the past 12 months, HSE has prosecuted four landowners/farmers for failing to take appropriate steps to stop walkers from being seriously injured on their land. One of these cases resulted in the tragic death of a 61-year-old grandmother [who was killed while enjoying a family walk in Northumberland](#).

HSE inspector Wayne Owen said: "All large animals can be a risk to people. Even a gentle knock from a cow can result in people being crushed or falling. All cattle should be treated with respect."

Farmers have a legal responsibility to manage their herds to reduce risk to people using footpaths and other rights of way.

Incidents in which walkers are killed or injured often involve cows with calves, or bulls. Often, those injured or killed have a dog with them.

Members of the public can find out about steps to safely enjoy the countryside and respect farming activities by following Government advice in [The Countryside Code – GOV.UK \(www.gov.uk\)](http://www.gov.uk).

Advice includes:

- Give livestock plenty of space. Their behaviour can be unpredictable, especially when they are with their young.
- Keep your dog under effective control to make sure it stays away from livestock. It is good practice wherever you are to keep your dog on a lead around livestock.
- Let your dog off the lead if you feel threatened by livestock. Releasing your dog will make it easier for you both to reach safety.

Mr Owen said: “Farmers should carefully consider the risk before putting cattle into fields with footpaths, for example cows and calves are best kept in alternative fields.

“Even docile cattle, when under stress, perhaps because of the weather, illness, unusual disturbance, or when maternal or other instincts are aroused, can become aggressive.

“Follow farming industry and HSE guidance to reduce the risk from animals and help people to enjoy your land and pass through smoothly.”



This year's campaign is focusing on livestock as well as farm vehicles

Key considerations for farmers and landowners include:

- No dairy bulls should be kept in fields with public access at any time.
- Where possible avoid putting cattle, especially cows with calves, in fields with public access.
- Where there is a need to keep cattle with calves or a bull in a field with public access, do all that you can to keep animals and people

separated. Consider the use of fencing (permanent or temporary e.g. electric fencing). This is particularly important at busy times or where access routes are heavily used.

- Assess the temperament of any cattle before putting them into a field with public access.
- If cattle, especially cows with calves, do need to be put into fields with public access, keep this period to a minimum.
- Position feed and water troughs away from public access routes and away from public entrances and exists to the field.
- Put in place a system to monitor any cattle in fields with public access at least on a daily basis. It may be worth recording this.
- Consider culling any animal that shows signs of aggression.
- Any animal that has shown any sign of aggression must not be kept in a field with public access.
- Clearly sign post all public access routes across the farm. Display signage at all entrances to the field stating what is in the field (cows with calves / bulls).

## Notes to editors

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.
2. HSE Guidance for England and Wales on putting cattle into fields with public rights of way / public access can be found here: [Cattle and public access in England and Wales \(hse.gov.uk\)](#)
3. HSE guidance for Scotland can be found here: [Cattle and public access in Scotland: Advice for farmers, landowners and other livestock keepers AIS17 \(hse.gov.uk\)](#).
4. Further advice, videos and free resources [Work Right Agriculture – Work Right to keep Britain safe](#)
5. There is also guidance available from other stakeholders for visitors to the countryside and farmers / landowners eg [The Countryside Code – GOV.UK \(www.gov.uk\)](#).
6. Further details on the latest [HSE news releases](#).

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## Company fined after 'perfect' son crushed to death

A company in Hertfordshire has been fined after an employee was crushed to death.

James Rourke lost his life after being struck and run over by an excavator at

Sarazen Gardens, Brampton on 18 November 2019.

James and his family had celebrated his sister Katie's 21<sup>st</sup> birthday the weekend before the fatal incident.



James Rourke

The 22-year-old site engineer had been attaching 'warning' work signs to fencing around the site when he was hit by the vehicle.

James, from Westcliff-on-Sea in Essex, had only joined his employer, Materials Movement Ltd, months before after graduating from the University of Birmingham with a degree in geology in the summer of 2019.

The firm had been hired to undertake ground clearance works at Sarazens Gardens in preparation for the building of new houses.

A Health and Safety Executive (HSE) investigation found Materials Movement Ltd had failed to plan and manage the work at Sarazen Gardens. The company failed to properly supervise the work that James and the excavator driver were undertaking to ensure it was safe. The Baldock firm also failed to ensure the work was planned and managed to eliminate any chance of James working near the excavator.

HSE guidance states employers must consider five main precautions needed to

control excavator hazards, these are; exclusion, clearance, visibility, plant and vehicle marshaller and bucket attachment. Further guidance on mobile plant and vehicles can be found at: [Construction – Mobile plant and vehicle industry health & safety \(hse.gov.uk\)](https://www.hse.gov.uk/construction-mobile-plant-vehicle/)

James' mother, Clare, said in her victim personal statement: "The sunshine has been taken from our lives and the dark gap is immense.

"Our profound loss is ever present; James is always missing. Missing from family events, Christmas, birthdays, holidays. Unknown to newborn family members. Unknown to new friends.

"Our house has a bedroom with no owner. Possessions we cannot bear to touch, photographs we cannot look at.

"We were an even family of six, now an odd family of five – incomplete, unbalanced."

Materials Movement Ltd, of Royston Road, Baldock, Hertfordshire, pleaded guilty to breaching Regulation 15(2) of the Construction (Design and Management) Regulations 2015. The company was fined £133,330 and ordered to pay £8,500 in costs at Peterborough Magistrates' Court on 22 March 2024.

HSE inspector Martin Paren said: "This tragic incident led to the avoidable death of a young man. This death could have easily been prevented if his employer had properly planned, instructed, and supervised the work.

"Our thoughts today are with the family of James, who should have been protected from such harm at work – because of the failings of Materials Movement Ltd he was not."

This prosecution was brought by HSE enforcement lawyer Jon Mack and supported by HSE paralegal officer David Shore.

Clare added: "James was perfect. He was a big part of our close family unit. He would do anything for us. We cherished him, dearly. He was a compassionate, valued friend to many and was known for his humour and gentle nature."

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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. In February 2020, Materials Movement Ltd was sentenced following a separate HSE prosecution. The company was fined £33,000 following the death of worker Stephen Hampton who died from an explosion on Swain's

## Engineering firm fined following worker's death

An engineering and services company has been fined following the death of a worker.

Alistair Hutton, a sub-contractor hired by NG Bailey Limited, lost his life while working on the construction of the Baird Family Hospital in Aberdeen on 18 January 2023.

He had been navigating a mobile elevating work platform (MEWP) along an unfinished corridor at the hospital when his head struck a metal lintel.

Mr Hutton, who lived in Forfar, immediately lost consciousness, and died at the scene shortly thereafter.

The 51-year-old was pronounced dead less than an hour after the incident.



Area of the corridor where the incident occurred

A Health and Safety Executive (HSE) investigation found NG Bailey Limited, the lead contractor for the project, had failed to consider overhead obstructions, especially during the transit of MEWPs on site. The assessments in place did not consider these risks despite HSE and industry guidance highlighting them and the available control measures.

HSE guidance states it is important that those responsible for selecting, specifying and managing MEWPs on site understand the risks associated with the use of a MEWP so they can advise on the precautions required to eliminate or control those risks. More on this can be found at: [Construction – Mobile elevating work platforms health & safety \(hse.gov.uk\)](https://www.hse.gov.uk/construction-mobile-elevating-work-platforms-health-safety/)

NG Bailey Limited, of Brown Lane West, Leeds, pleaded guilty to breaching Sections 3(1) and 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined £135,000 and ordered to pay a victim surcharge of £10,125 at Aberdeen Sheriff Court on 21 March 2024.

HSE inspector Graham McEvoy said: “There was a failure by NG Bailey Limited to consider available guidance and the work that was being done, which led to inadequate risk control measures being implemented and unsafe working practices developing.

“Companies should be aware that HSE will not hesitate to take appropriate enforcement action against those that fall below the required standards. Our thoughts remain with Mr Hutton’s family and friends.”

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## **Health board fined £220,000 following death of patients**

Lothian Health Board has been fined £220,000 for safety breaches, following the death of two vulnerable patients.

Both were being cared for at the Western General Hospital in Edinburgh at the time of their deaths.

On 29 October 2017, one of the patients, then aged 55, was in the care of the Neurosurgery Ward following an attempt to take his own life in which he sustained a head injury. While in the care of the ward he fell more than 11 metres to his death from a second-floor window. The window in his room was not restricted to the required 100mm opening gap.



The Health and Safety Executive (HSE) investigation revealed a failure to ensure that the patient was in a room which had [windows that had been suitably restricted](#). The patient had undergone surgery which can cause confusion, delirium, and anxiety. It was considered to be foreseeable that patients in a state of confusion could be at increased risk.

On 23 January 2021, a second patient, then aged 79, was being cared for on the Medial Assessment Unit. He was presenting with hallucinations, confusion, distress and showing signs of delirium. After multiple attempts to abscond over the following days, he left the ward and was found some five hours later in the hospital canteen preparation room having fallen from a first-floor window. He did not regain consciousness and his condition declined until he sadly passed away on 8 February 2021.



One of the patients was found some five hours later in the hospital canteen preparation room having fallen from a first-floor window

Plans to transfer the patient to a secure ward to manage his condition had been considered. However, at the time of his admission the transfer of patients between different wards in the hospital was strictly controlled in order to reduce the risks of Covid infections. He was therefore not transferred to a more suitable ward with the necessary security facilities to prevent him from absconding.

At Edinburgh Sheriff Court on 19 March 2024, Lothian Health Board of Waterloo Place, Edinburgh pleaded guilty to breaching Regulations Section 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. They were fined £45,000 in relation to the first incident and £175,000 for the second.

Speaking after the case, HSE inspector Kerry Cringan said: "Two vulnerable gentlemen who were in hospital to receive care lost their lives in these tragic incidents. Lothian Health Board failed to ensure the risks patients of falling from windows were adequately managed.



“All companies operating in the health and social care sector are required to ensure that systems of work are in place to ensure those in their care are safe. The risk of falls from windows is well-known and there are standards for opening sizes that must be achieved. HSE will not hesitate to take appropriate enforcement action against those that fall below the required standards.”

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## [Metal processing firm fined after man suffers life changing injuries](#)

A metal processing company has been fined £12,000 after an employee sustained life changing injuries at an incident at a premises in the Oldbury in the West Midlands.

Independent Slitters Limited carries out metal slitting at the facility – a process that involves coils of metal being split into various lengths. On 3 May 2022, 53-year-old Peter Daniels, husband and father of one, had a finger severed and a de-gloving of his right hand.

Guidance by the Health and Safety Executive (HSE) says employers should consider [how workers use machinery and ensure it remains safe to use](#).



The worker had a finger severed in the incident at the company's Park Street facility in Oldbury

Birmingham Magistrates' Court heard Mr Daniels was in the final stages of setting up one of the slitting lines operated by the company at its facility on Park Street when the incident took place. His right hand was degloved and his middle finger badly damaged. He spent 11 days in hospital, undergoing several surgeries, which included the amputation of the middle finger as well as skin grafts.

An HSE investigation found the company did not have in place a system of work to ensure that the activity of setting and checking the blades on the slitting head rollers could be carried out safely. The risk assessment for the wide slitting line was not suitable and sufficient and did not consider the risks to employees when setting the blades.

Independent Slitters Limited of Park Street, Church Bridge, Oldbury, Warley, West Midlands pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. On 18 March 2024, the company was fined £12,000 and ordered to pay costs of £4,592.

After the hearing, HSE inspector Sarah Smewin commented: "The injuries that Mr Daniels suffered have impacted on all aspects of his life and resulted in him having to undergo numerous operations.

"The risks arising from working near to the dangerous moving parts of machinery are well known. Employers must assess their workplace for these risks and act to ensure that effective measures are in place to prevent access to dangerous, moving parts of machinery."

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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 [working safely with machinery](#) is available.