

Company fined after 3-year-old nearly drowned at children's holiday camp

- Three-year-old girl found unconscious during swimming pool free-play session.
- Child became trapped beneath large float during holiday camp activity.
- HSE investigation found inadequate safety documentation and communication.

A company that runs holiday camps for children across the country has been fined £6,000 after a three-year-old girl nearly drowned during a swimming pool free-play session.

The incident occurred on 26 July 2023 at Bishopsgate School in Egham, Surrey, where Oxford Active Ltd was running a holiday camp. The three-year-old girl was found face down in the swimming pool underneath a large float and was not breathing. Staff intervened and were able to resuscitate her.



The float involved

The girl was part of a group of 19 children aged between three and five who were taking part in a free-play swimming session. Most of the children were non-swimmers, including the three-year-old. Staff had fitted her with two sets of armbands and provided her with a foam noodle before she entered the pool. A number of floats were present in the pool, including a large rocket-shaped float, beneath which the child became trapped. When she was found unconscious, she was no longer wearing the armbands or using the noodle.

An investigation by the Health and Safety Executive (HSE) found that Oxford Active Ltd's documentation relating to pool safety and supervision was insufficiently detailed and lacked clarity. The investigation also found that the content of this documentation was not communicated effectively to staff, meaning appropriate control measures were not properly understood or implemented.

HSE guidance on [swimming pool management](#) highlights the importance of effective supervision arrangements, particularly where young or non-swimming children are involved. This includes ensuring suitable adult-to-child ratios, clear rules on the use of floats and inflatable equipment, robust risk assessments for free-play sessions, and effective emergency procedures so incidents can be identified and responded to immediately.

Oxford Active Ltd, of Oxford, pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc. Act 1974. The company was fined £6,000 and ordered to pay £12,000 in costs at a hearing at Chichester Magistrates' Court. A victim surcharge was also applied, amounting to forty percent of the fine, capped at £2,000. In addition, £2,000 compensation was awarded to the child's family.

After the hearing, HSE Inspector Russell Beckett said:

"It is vital that children are able to learn to swim in a safe environment and that parents can trust their children will be properly looked after while doing so.

"Fortunately, the three-year-old child recovered well, but this incident could very easily have had a tragic outcome."

This HSE prosecution was brought by enforcement lawyer, Neenu Bains and paralegal officer, Farhat Basir.

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: [Swimming pool management: Leisure activities](#)
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](#).

[Major chemical firm hit with £400,000 fine after dangerous steam release](#)

A global chemicals company has been fined £400,000 after a worker narrowly

escaped serious injury in a high-pressure steam release incident at its site in Huddersfield.

Syngenta Ltd was sentenced after the 59-year-old contractor – working under its control and direction – had been carrying out unsafe maintenance work. The man had been working as a mechanical fitter on 6 November 2023 when the incident took place, resulting in the company reporting it to the Health and Safety Executive (HSE) as a dangerous occurrence. The incident involved a release of high-pressure steam as he went about his job.

The company operates a large agrichemicals production site where some of the production plants rely on high pressure steam to manufacture products. The HSE investigation found that the incident occurred during the planned replacement of a faulty steam trap on small-bore pipework.

Steam traps are devices that automatically remove condensate (water) and air from the high-pressure steam system. There was a sudden failure of the valve used to isolate the work location from the steam, and this resulted in the uncontrolled high-pressure release.

The HSE investigation also revealed several failures with the system of work in operation. These included:

- The isolation valve failed when the mechanical fitter was separating a bolted flange by cutting the bolts using a battery powered reciprocating saw.
- The isolation valve and flange bolts were affected by corrosion and were in a poor condition.
- Due to widespread corrosion of flange bolts on the steam distribution system, it was considered necessary to routinely cut bolts rather than unscrew them using a spanner.
- Cutting flange bolts reduces the ability to control any unexpected, trapped material or pressure remaining in the pipework.

Syngenta Ltd pleaded guilty to having failed to ensure that the isolation valve and flange bolts were maintained in an efficient state, in efficient working order and in good repair – as required by Regulation 5(1) of the [Provision and Use of Work Equipment Regulations 1998 \(PUWER\) – HSE](#).

In addition, there was an issue with the company's documented risk assessment procedure in place before such maintenance work was undertaken. It was routine for Syngenta to carry out maintenance work on small-bore pipework of the high-pressure steam distribution system, using a single method of isolation.

HSE's published guidance about on this subject ([The safe isolation of plant and equipment – HSE](#), HSG253) emphasizes that using a method of double isolation is safer. The risk assessment documents in place failed to appreciate the increased risk involved in relying on a single method of isolation when there was known corrosion of the work equipment. Syngenta Ltd also pleaded guilty to having failed to make a suitable and sufficient assessment of the risk involved in carrying out the specific maintenance work

described as required by Regulation 3(1) of the [The Management of Health and Safety at Work Regulations 1999](#).

Syngenta Ltd, whose head office is at Bracknell, Berkshire pleaded guilty to the two offences at Leeds Magistrates' Court on 28 January 2026 and was fined £400,000 and ordered to pay costs of £8,288.

HSE Inspector David Welsh said: "If a safe system of work had been in place at the site when the maintenance was being carried out, this dangerous incident would not have happened.

"The company did not appreciate the extent of the risk posed because of the way the maintenance work was being done, and the relatively simple control measures that could have been applied to make it safer.

"Syngenta not only failed produce an appropriate risk assessment, but also failed to maintain work equipment in a safe condition – which taken together meant that this was a dangerous accident waiting to happen."

This HSE prosecution was brought by enforcement lawyer Iain Jordan and paralegal officer Zara Salman.

Further information:

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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. Relevant guidance can be found here: [The safe isolation of plant and equipment – HSE](#)
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Sole trader fined after worker injured in fall from height

- Worker suffered life-changing injuries after falling through fragile rooflight.
- HSE investigation found no measures in place to prevent or mitigate a fall.

- Incident highlights ongoing risks of working at height in construction.

Daniel Jenner, trading as Jenner Roofing and Building Services, has received an eight-month suspended sentence after a worker fell four metres through a rooflight to the concrete floor below.



The hole left in the roof

The incident occurred on 12 August 2023, when a worker was carrying out work on behalf of Jenner Roofing and Building Services, at an industrial estate in High Wycombe, working alone to clean and repair gutters and drains.

While walking next to the unguarded edges of the roof, he approached a fragile roof covering above a service road. He stepped onto a rooflight, fell through it, and sustained serious, life-changing injuries including a fractured skull and cheekbone, a fractured leg and a broken wrist.



Police at the scene of the fall

An investigation by the Health and Safety Executive (HSE) found that Daniel Jenner had failed to implement any work-at-height measures to prevent workers from falling from the unguarded edges of the roof or through the fragile roof itself. There were no measures in place to mitigate for either the distance or the impact of a fall.

Working at height remains one of the leading causes of workplace injury and

death. HSE has detailed guidance available on [working safely at height and managing construction activities](#) that can be found on our website.

Daniel Jenner, trading as Jenner Roofing and Building Services, pleaded guilty to breaching Regulation 6(3) of the Work at Height Regulations 2005. He received an eight-month suspended sentence, was ordered to complete 280 hours of unpaid work and to pay £500 in costs at a hearing at High Wycombe Magistrates' Court on Wednesday 21 January 2026.

HSE Lead Inspector, Sophie Neale, said:

“This was a tragic but avoidable incident, where an individual suffered life-changing injuries due to working at height. Had suitable control measures been implemented, such as fall prevention or fall mitigation measures, this incident would not have occurred.

“This prosecution highlights ongoing safety failures in the construction industry, where working at height remains one of the leading causes of workplace injury and death.”

This HSE prosecution was brought by HSE enforcement lawyer, Gemma Zakrzewski and paralegal officer, Helen Hugo.

Further information:

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[HSE inspections tackling exposure to flour dust in bakeries](#)

The Health and Safety Executive (HSE) is carrying out a series of inspections at large bakeries across Great Britain from January 2026.

Inspectors will check that employers are properly protecting workers from the

dangers of dusty ingredients including flour dust.

Exposure to certain dusty ingredients can lead to occupational asthma, a serious and potentially life-changing condition, with flour dust being one of the most common causes of occupational asthma in Great Britain. Exposure to other dusty ingredients, such as bread improver enzymes, can also cause respiratory sensitisation.

Dust can cause the airways to become hypersensitive. Once a worker becomes sensitised, even small amounts of dust can trigger asthma symptoms, and in many cases the condition is irreversible.

The danger for workers in bakeries is that dust generated from flour and other ingredients can linger in the atmosphere if it is not properly controlled, and many common tasks are high-risk, including dusting flour during dough handling, tipping and dispensing dry ingredients, and cleaning up flour spills.

Employers must follow the hierarchy of controls under the Control of Substances Hazardous to Health Regulations (COSHH), and HSE inspectors will assess bakeries' compliance with COSHH regulations, focusing on whether employers have correctly considered their measures for managing risk in order of effectiveness:

- Eliminating dusty processes (such as using non-stick belts instead of flour as a lubricant, or using sensors to stop flour dusters when products are not present)
- Substituting dusty ingredients with alternatives (such as low-dust flour or liquid/gel-based ingredients)
- Engineering controls like local exhaust ventilation
- Respiratory protective equipment as a last resort

Inspectors will also check that employers have health surveillance in place for workers exposed to dusty ingredients.

Mike Calcutt, Deputy Director in HSE's Engagement and Policy Division, said: "Too many workers in bakeries are suffering from unnecessary exposure to dusty ingredients including flour. When employers prevent exposure, the risk of asthma is removed. That's the key principle we want bakeries to apply.

"It may be possible to reduce the risk with ventilation or protective equipment, but these controls should not be selected where elimination and substitution would be effective. I urge employers to carefully consider dusty processes, eliminating risk and substituting to prevent exposure by weighing the long-term benefits in sustaining prevention against the true cost of ill-health and using controls lower in the hierarchy."

HSE has seen the benefits of correct application of the hierarchy of controls in previous inspections, when a large bakery transformed its approach. The company assessed its use of flour nationally and trialled low-dust flours and dust suppressants, which dramatically reduced dust exposure, reducing the risk to workers. By focusing on eliminating and substituting flour in the

first instance, the company was able to implement fewer mechanical controls and reduce the time and cost needed to extract dust from the atmosphere.

HSE has well-established [guidance on controlling flour dust in bakeries](#) available at [hse.gov.uk](https://www.hse.gov.uk).

Low-dust flour is now an established standard, and the Federation of Bakers' Blue Book provides industry-specific guidance on dust control and health surveillance. Employers are encouraged to review these resources and ensure their control measures meet the required standards.

Notes to editors:

- The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety.
- HSE [guidance on controlling flour dust in bakeries](#)
- The Federation of Bakers' Blue Book provides industry guidance on dust control and health surveillance.
- Common dusty tasks in bakeries include dusting flour during dough handling, hand application of flour at conveyor belts and rollers, flour bag tipping, weighing out ingredients, sack disposal, and cleaning up.
- Flour spills should never be cleaned using dry sweeping or compressed air. An industrial vacuum cleaner (minimum M class) or wet cleaning methods should be used.

[Company fined after operative receives fatal head injury at work](#)

- Worker fatally injured after becoming entangled in unguarded machinery.
- HSE investigation found failure to prevent access to dangerous moving parts.
- Company could have implemented recognised industry safety measures.

A South Yorkshire wire company has been sentenced following serious health and safety breaches after a worker sustained fatal injuries at its premises in Penistone.

Sheffield Magistrates' Court heard how, on 18 November 2021, an operative died after becoming entangled in an unguarded wire drawing and recoiling machine at Stanley Wire Limited's site on Talbot Road. The machine, known as a 'Gravity Block', had exposed moving parts which the worker was able to access.



The machine, known as a 'Gravity Block'

The incident resulted in the operative sustaining fatal head injuries.

An investigation by the Health and Safety Executive (HSE) found that the company had failed to take effective measures to prevent employees from accessing dangerous moving parts of the wire drawing machine. The investigation identified that the company should have carried out a suitable and sufficient risk assessment for the machine, and subsequently developed a safe system of work and clearly communicated this to its workforce.

HSE also found that fixed closed guards, interlocks or pressure mats should have been installed to prevent operatives from entering the Gravity Block while it was rotating. The company could have appointed a designated competent person on site and provided formal training to operatives, rather than relying on verbal instruction.

Recognised industry-standard safety measures could and should have been implemented on a number of machines, instead of allowing substandard conditions to persist over a prolonged period.

HSE has detailed guidance on the safe use of work equipment and machinery guarding, including the requirements under the Provision and Use of Work Equipment Regulations (PUWER), which is available at: [Provision and Use of Work Equipment Regulations 1998 \(PUWER\) – HSE](#)

Stanley Wire Limited, of Stanley Mills, Talbot Road, Penistone, South Yorkshire, after pleading guilty at an early hearing of breaching Section 2(1) of the Health and Safety at Work etc Act 1974. The company was fined £140,000 and ordered to pay £6,652 in costs.

After the hearing, HSE Inspector Charlotte Bligh said:

“Following the incident, eight Prohibition Notices were served on the company. The remedial action taken demonstrated that appropriate measures, such as effective guarding, were readily available and could have been put in place had the risks associated with the activity been properly considered.

“Companies are reminded that HSE will not hesitate to take appropriate enforcement action against those that fall below the required health and safety standards.”

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

Further information:

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