

Roofing company fined £16,650 after employee fell through skylight opening

- Employee sustained serious injuries after fall from height
- Company failed to implement safety measures for work at height activities
- Kingsley Roofing Contractors Limited fined £16,650

A Northampton roofing company has been fined £16,650 after an employee suffered serious injuries when he fell through a skylight opening.

Ryan Robinson, 31, was working for Kingsley Roofing Contractors Limited to recover a flat roof of single-storey extension at a domestic property on Sywell Road in Northampton.

Covers that had been installed over two large skylight openings had to be removed as part of preparation. Mr Robinson fell through one of these openings whilst removing material from the other, falling over three metres to the ground. His injuries required surgery and long-term treatment.

An investigation by the Health and Safety Executive (HSE) found that Kingsley Roofing Contractors Limited failed to properly plan work at height activities and implement measures that would have prevented their employees from falling through the skylight openings.

HSE guidance states employers must ensure that work at height is properly planned, appropriately supervised and carried out in a manner that is, so far as is reasonably practicable, safe. This means that control measures must be in place to prevent or protect from falls. In this case, a crash deck or safety netting under the openings would have prevented serious injury from occurring. Further guidance for working at height can be found at [Health and safety in roof work – HSE](#).

Kingsley Roofing Contractors Limited of Chartergate, Clayfield Close, Moulton Park, Northampton pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc Act 1974. The company was fined £16,650 and ordered to pay £7,205 in costs and £2,000 victim surcharge at Birmingham Magistrates' Court on 20 November 2025.

HSE Inspector, Chris Bennet, said: "Falls from height are the most common kinds of fatal accidents, accounting for over a quarter of fatal injuries to workers in 2024/25. This could be avoided through proper planning and implementation of effective controls.

"The fine imposed on Kingsley Roofing Contractors should underline to everyone in the construction industry that the courts, and HSE, take a failure to plan works at height extremely seriously. It is the duty of employers to ensure that everyone working on a building site returns home safely."

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. Further relevant guidance can be found at [Roof work – HSE](#) and [Health and safety in roof work – 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](#).

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Manufacturer fined £16,000 after 18-year-old breaks arm in workplace accident

- Workplace safety failure results in serious injury to young employee

- Health and Safety Executive (HSE) found that Isoma Limited had failed to carry out a suitable and sufficient risk assessment
- Isoma Limited fined £16,000

A conveyor systems manufacturer based in Swadlincote has been fined £16,500 after an 18-year-old employee broke his arm when he became entangled in a manual lathe while deburring with emery cloth.

The incident happened on 1 December 2023 at Isoma Limited's factory at George Holmes Business Park, Swadlincote. The young employee was deburring by hand without using a protective appliance when his arm became caught in the rotating lathe.

An investigation by the Health and Safety Executive (HSE) found that Isoma Limited failed to provide a safe system of work or a risk assessment for deburring components.



Manual lathe at Isoma Ltd Factory

HSE guidance states that employers must carry out a suitable and sufficient assessment of the risks from using emery cloth to polish, deburr or size a metal component while it is rotating in a manual lathe. The risk assessment should determine whether the use of emery cloth can be eliminated completely. Where this is not practicable, a safe method of using emery cloth on a rotating manual metalworking lathe must be implemented. Relevant guidance can be found at [HSE's website](#).

Isoma Ltd, of George Holmes Way, Swadlincote, Derbyshire, DE11 9DF pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. The company was fined £16,000 and ordered to pay £4,357.77 in costs and £2,000 victim surcharge at Chesterfield Magistrates' Court on 20 November

2025.

HSE investigating inspector Nicole Riley said: "Every year there are accidents involving the use of emery cloths on metalworking lathes, resulting in serious injuries. This incident could have been avoided if Isoma Limited had put in place a suitable safe system of work for employees deburring workpieces on manual lathes. There is clear guidance available to companies who undertake this work."

This HSE prosecution was brought by HSE enforcement lawyer Andy Siddall and paralegal officer Lynne Thomas.

Further Information:

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2. More information about the [legislation](#) referred to in this case is available.
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4. Relevant guidance can be found here
<https://www.hse.gov.uk/engineering/lathes.htm>
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Health and Safety Executive Webinar: Offshore UKCS Process Isolations – Regulatory Expectations and Learnings

The Health and Safety Executive (HSE) is hosting a webinar on process isolations in the offshore oil and gas sector, aimed at driving improvement in this critical safety area.

The free online event will take place on 4 December 2025 from 10:30 to 11:30.

Why this matters

Process isolations are a key barrier to preventing major accident hazards when carrying out intrusive work offshore. They involve systems of work and mechanical equipment, such as valves, to prevent the release of flammable and

hazardous substances.

HSE continues to investigate loss of containment incidents associated with isolations and finds significant failings during inspections. Process isolations therefore remain a focus area during duty holder interventions.

What attendees will learn

The webinar will reinforce legal requirements and expected practice in the UK Continental Shelf (UKCS) offshore and oil and gas sector, using key findings from incidents and regulatory inspections to highlight failings and provide learning opportunities.

Topics covered will include:

- Potential major accident hazards during use of isolations
- Isolation design and selection of standards
- Risk assessment and use of variations from benchmark standards
- Planning and preparation of isolations, including draining, venting, purging and flushing
- Installation, including integrity testing
- Training and competence
- Monitoring, audit and review

The seminar will be presented by Kelly Rose, Editor, Health & Safety Matters, Ashley Hall, Process Safety Specialist, HSE and James McCrae, Process Safety Specialist, HSE.

Who should attend

This webinar is intended for all those involved in isolation activities for offshore installations in the UKCS, from design, installation, approval and audit.

All attendees will receive a CPD certificate.

Howard Harte, Operations Manager (Offshore Regulation) at the Health and Safety Executive, said: "A key part of our role is to highlight the challenges and failings our inspectors identify in the industry, and process isolations continue to lead to incidents requiring HSE investigations.

"This webinar will share our findings to help companies drive self-improvement, as we look to collaborate and work together to improve safety across the industry."

Registration

To register for this webinar, visit [Offshore UKCS Process Isolations – Regulatory Expectations and Learnings](#).

Registration closes on 3 December 2025.

For registration queries, contact Western Business Media Ltd on

marketing@westernbusiness.media or 01342 314 300.

Further Information:

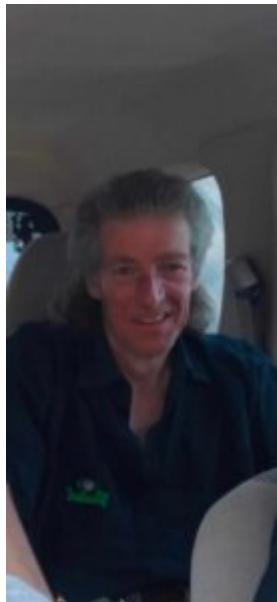
1. The webinar is delivered by the Health and Safety Executive
2. The event is organised by Western Business Media Ltd
3. By registering, attendees agree to be contacted by the organiser and event sponsors

Much loved man lost his life 'due to cost of 50 pence screw' say family

- Alban Watts died due to a 'basic and simple' failure.
- Dangerous parts of machinery had inadequate guarding.
- HSE guidance on working with machinery is available.

The family of a much loved man from Cumbria have spoken of their anger that his life was worth less than "the cost of a 50 pence screw".

Alban Watts was killed while working for egg producer Bell Mount Farming Limited at its site in Great Salkeld in Penrith on 11 January 2023. The 61-year-old, who lived in the village of Blencow, died after being strangled, when his clothes became entangled in a hen feeding system at the farm.



Alban Watts was killed when his clothing became entangled in unguarded machinery

Speaking after the company was fined £50,000, his brother Martin and sister Louise Robinson spoke of their sadness and anger at his death.

"Losing Alban has taken a part of our trio, without him we are an incomplete

unit," the siblings said.

"Not a day goes by where he is not missed.

"Alban worked at Bell Mount for 12 years and he enjoyed his job. But it's taken the life of a member of our family for them to do their job.

"We are angry that his life was worth less than a 50p screw to a multi-million pound company. Such a small item could have saved his life. You can't replace a person who meant so much to us."



The machine was examined at HSE's site in Buxton

An investigation by the Health and Safety Executive (HSE) found that Bell Mount Farming Limited failed to prevent access to dangerous parts of machinery – in this case the rotating sprocket of the drive mechanism which powered the feeding system in the poultry shed. The system operated for three minute periods at set times throughout the day; the remainder of the time it was motionless.

Mr Watts was working alone in one of the poultry sheds when his clothing came into contact with the unguarded sprocket during one of these feeding periods, causing it to become entangled. The investigation also identified that the guard designed to prevent such access was not fixed in place and could simply be lifted off.

Further examination of the guard identified that the bolt holes in the guard were stripped, preventing it from being secured to the frame of the drive unit. Additionally, these holes in the guard did not align with those in the frame, making it impossible for the guard to be fixed securely.



One of the bolt holes on the guard

Alban's mother Noreen said her son was an accomplished mechanic, joiner and carpenter and that his death had been 'cruel'.

"Mere words cannot express the horror and distress of hearing such an awful death and I can only hope Alban didn't suffer," she said.

"I have now had to go through every parent's nightmare of surviving their own child, in tragic circumstances.

"Above all, I want lessons to be learnt from this tragedy.

"Due to the lack of a machine guard, my dear son Alban has been killed and taken from me."

HSE guidance states employers must take effective measures to prevent access to dangerous parts of machinery. This will normally be fixed guards which prevent persons coming into contact with those parts and require a tool to be removed; this was the expected control in this instance. Further guidance can be found here [Provision and Use of Work Equipment Regulations 1998 \(PUWER\) – HSE](#).

Bell Mount Farming Limited, of Stainton, Penrith, pleaded guilty to breaching Regulation 11(1)(a) of the Provision and Use of Work Equipment Regulations 1998. The company was fined £50,000 and ordered to pay £6,038 in costs at a hearing at Warrington Magistrates' Court on 20 November 2025.

After the hearing HSE Inspector Matthew Shepherd said: "What is most tragic about this case is the failure of the company was such a basic and simple one.

"What was such an easy fault to fix cost a much loved man his life and left a family without a brother and a son.

"Preventing access to dangerous parts of machinery is a well-known and long-standing part of any health and safety management system.

"Alban's death shows the importance of ensuring machinery is adequately guarded and the devastating consequences of getting it wrong.

"We will not hesitate to take action against companies which do not do all that they should to keep people safe."

This HSE prosecution was brought by HSE enforcement lawyer Matthew Reynolds and paralegal officer Farhat Basir.

Further information:

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