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:

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.
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.

Company fined after man seriously injured during home extension work

A Herefordshire-based conservatory manufacturer and installation company has been fined £40,000 after an employee fell through the roof of a first-floor orangery home extension.

Leslie Baker was one of several employees of Atrium Conservatories Limited, working to install an orangery extension covering the footprint of a former first-floor balcony at a house in Abberley, Worcestershire on 9 February 2024.

While working on the roof trusses, Mr Baker, who was 56 at the time, stepped onto an unguarded opening for a future skylight, resulting in him falling approximately two metres to the floor below. He sustained a serious head injury, several broken ribs, a ruptured spleen and kidney damage. He remained intubated in hospital for approximately two weeks before surgery could be attempted.


Mr Baker fell from height while working on installing an orangery

The long term impact on Mr Baker has been profound both physically, as his mobility has been affected long term, and mentally as he has since been diagnosed with PTSD.

An investigation by the Health and Safety Executive (HSE) found that no external scaffold had been put into place around the perimeter of the extension to provide safe access or prevent falls to the ground below. Additionally, there were no measures in place internally to prevent falls into the extension.

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

The HSE investigation also found that Atrium Conservatories Limited had failed to properly plan the work and to provide its workers with suitable instructions for carrying out their duties safely.

Atrium Conservatories Limited of Kington, Herefordshire, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work Act 1974. They were fined £40,000 and ordered to pay £5,309 in costs at a hearing at Kidderminster Magistrates' Court on 26 June 2025.

HSE Inspector Jo Quigley said "Working at height remains one of the leading causes of workplace injury and death.

"This incident could have easily had fatal consequence and it highlights the importance of undertaking a thorough assessment of the risks for all work at height activities. Suitable control measures, such as internal crash deck, should also be implemented to minimise the risk of serious personal injury.

“Every company that carries out building alterations must understand they are undertaking construction work; and therefore ensure they put in place suitable control and management measures throughout the duration of the work to the same standards as the wider construction industry.”

This prosecution was brought by HSE enforcement lawyer Julian White and paralegal officer Rebecca Withell.

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 England and Wales can be found here and for those in Scotland here.
5. HSE guidance on working safely at height is available.

Airport fined for failures that led to a man’s death

An airport company has been fined £144,050 for failures that led to the tragic death of a 59-year-old man.

Glasgow Prestwick Airport Limited pled guilty to a breach of health and safety legislation at Ayr Sheriff Court after Joseph Dempsey, an experienced member of the ground handling team, died when a corroded guardrail gave way and he fell to the tarmac below.

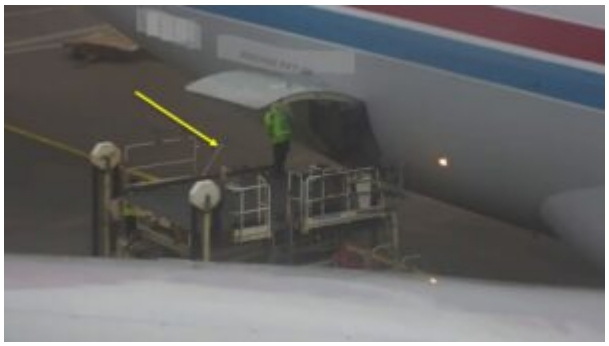
The procurator fiscal told the court the fatal incident happened at Prestwick Airport on Wednesday 11 January 2023.

Screenshot of CCTV footage captured by an airport camera overlooking the apron, showing the incident platform loader in situ, at the open door of the rear (right) aircraft cargo hold

The prosecutor described how Mr Dempsey was preparing to unload cargo from an aircraft using a pallet loader. He had positioned the loader and was repositioning a guardrail when it suddenly gave way and Mr Dempsey fell to the tarmac, about 10 feet below.

Mr Dempsey’s colleagues immediately went to his assistance and paramedics attempted CPR and advanced life support. These efforts proved unsuccessful and he was pronounced dead at the scene.

The Health and Safety Executive investigation found that one of the guardrail posts had completely fractured. There were visible signs of significant corrosion, discolouration and flaking white paint around the area.



Close-up view

Metallurgical examination of the guardrail posts found differences in chemical composition, manufacturing, and wall thickness which indicated the posts were manufactured from two different tubing sections.

These welded sections were not a feature of the manufacture’s original design and appear to have been modified while the loader was under the ownership of Prestwick Airport. The welds on both the guardrail posts contained defects which would allow moisture in, creating a corrosive environment and speeding up deterioration.

There was no record of any modification or repair to the loader guardrail involving welding and the maintenance programme in place at the time did not cover the parts of the guardrail where failure or deterioration could lead to health and safety risks.

The charge libelled by the Procurator Fiscal and accepted by the company is

that they failed to ensure that the pallet loader was maintained and in good repair.

They failed to have in place a suitable and adequate maintenance and inspection programme to identify deterioration of and corrosion to the safety guardrails fitted to the container loader.

As a consequence of Prestwick Airports failure, Joseph Dempsey fell from the platform when part of a safety guardrail gave way due to corrosion and sustained severe injuries from which he died.

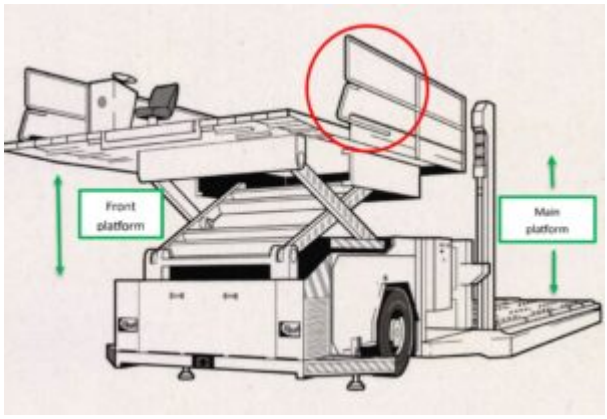


Diagram of the front of the loader. The area circled shows the front guardrail which failed (not in extended position)

Since the incident, Prestwick Airport has undertaken a review of all work at height.

Checks of the guardrails on the platform loaders have been added to the list of checks conducted during the annual service and inspection schedule and the failed guardrail was replaced by a new rail from the manufacturer.

Graeme McMinn HM Principal Inspector of Health and Safety added:

“Employers have an absolute legal duty to ensure that equipment they use at work is maintained in an efficient state and in good repair and full working order.

“This incident is a tragic reminder of what can result when that does not happen.”

Glasgow Prestwick Airport Limited pled guilty to a charge contrary to Regulations 5(1) of the Provision and Use of Work Equipment Regulations1998 and Section 33 (1)(c) of the Health and Safety at Work etc. Act 1974 at Ayr Sheriff Court on 25 June 2025. The company was fined £134,000 with a Victim Surcharge of £10,050.

Speaking after the sentencing, Debbie Carroll, who leads on health and safety investigations for the COPFS, said:

“Joseph Dempsey lost his life in circumstances which could have been avoided if Prestwick Airport had in place a suitable and adequate maintenance and inspection programme to ensure the equipment he was using was in a good state

of repair.

“This prosecution should remind duty holders that a failure to fulfil their obligations can have fatal consequences and they will be held accountable for this failure.”

Further information:

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Grocery wholesaler fined £1 million after worker killed by reversing HGV

A London-based grocery supplier has been fined £1 million after a worker was killed by a reversing HGV during a delivery in Manchester.

Lee Warburton, 53, a father of three from Stockport, was employed by Bestway Northern Limited, a wholesale supplier serving independent supermarkets across Britain, when the incident occurred.

On 19 February 2019, Mr Warburton and a colleague were making a delivery to a store in central Manchester. He was acting as a banksman, directing his colleague who was reversing the HGV. While attempting to guide the vehicle into the unloading area, Mr Warburton became trapped between the vehicle and a wall. He sustained fatal crush injuries.

Lee Warburton

Lee Warburton's partner, Hayley Tomlinson, described the day he died as the worst of her life. "To be taken in such a cruel manner made it even harder," she said. "Knowing the pain and fear Lee must have gone through was unbearable. But nothing compares to the moment I had to tell our children their daddy was never coming home."

She spoke of the long-term impact on their daughters, who were just nine and ten at the time. Both have suffered serious mental health challenges, including depression, bullying and social isolation. "It broke my children's spirits; they lost the sparkle in their eyes," she said. "Lee was their hero."

"My children will miss out on all the milestones Lee should have been here for – walking them down the aisle, meeting their first child. They miss the cuddles, the love he showed them, the days out. This has changed our lives forever."

A Health and Safety Executive (HSE) investigation found that Bestway Northern Limited, of Abbey Road, Park Royal, London, had failed to implement a safe system of work for vehicle movements. The company also failed to adequately assess the risks involved in the task or provide sufficient training for employees acting as banksmen.

Reversing HGV

HSE provides free guidance to employers at hse.gov.uk including specific guidance on workplace transport and reversing – Reversing – HSE.

Bestway Northern Limited pleaded guilty to breaching regulation 2(1) of the Health and Safety at Work etc Act 1974. The company was fined £1 million and ordered to pay full prosecution costs of £11,950.07 at a hearing at Manchester Magistrates' Court on Friday 18 June 2024.

After the hearing, HSE inspector Jane Carroll said:

"The company had failed to implement a safe system of work for its delivery and unloading activities, thereby exposing employees and others to the risk of being struck or caught by workplace vehicles.

"Nearly a quarter of all deaths involving workplace transport occur during reversing, most of which can be avoided by taking simple precautions.

“All work settings involving vehicles need to consider the risks arising from their use and implement adequate measures to ensure the safety of those involved in these activities.”

The prosecution was supported by HSE enforcement lawyer Chloe Ward and paralegal officer Rebecca Whithell.

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