

# Publication consultation opens on restricting PFAS in firefighting foams

- Six-month consultation seeks views on UK REACH technical dossier and proposed restrictions.

The Health and Safety Executive (HSE), in its role as the Agency for UK REACH, today opened a six-month public consultation to gather stakeholder views on per- and polyfluoroalkyl substances (PFAS) in firefighting foams.

The opening of the UK REACH consultation links to the publication of the Annex 15 restriction report, which presents HSE's scientific analysis and evidence base for potential restrictions on PFAS use in firefighting foams in Great Britain.

The consultation provides an opportunity for those who use foams from industry, and other stakeholders, such as trade associations, to comment on the proposals before the opinions are made and sent to the Defra Secretary of State, and the Scottish and Welsh Governments for a decision on whether to bring a restriction into law.

Dr Richard Daniels, HSE's Director of Chemicals Regulation Division said: "HSE's proposals have been developed through robust scientific methodology and where possible we have spoken with interested parties from across Great Britain. Now we are looking for more information from our stakeholders.

"We're seeking evidence-based feedback on our analysis to ensure any future restrictions are proportionate, effective and tailored to Great Britain's specific needs."

This work takes forward the recommendation from our analysis in 2023 that PFAS in firefighting foams are prioritised for action ahead of other uses of PFAS, as firefighting foams are one of the largest sources of direct releases to the environment.

The consultation runs until 18 February 2026 and full details, including the restriction report and supporting documents, are available [here](#). HSE has also published a [Q&A document](#) to help stakeholders understand the scope and limitations of the consultation.

## **Further information:**

1. PFAS are persistent chemicals covering thousands of substances used across many industrial sectors
2. The consultation focuses solely on PFAS in firefighting foams and does not cover other PFAS uses or legacy contamination
3. The 2023 Regulatory Management Options Analysis, which recommended prioritising PFAS in firefighting foams for action, can be found here –

[Analysis of the most appropriate regulatory management options.](#)

4. Questions outside the scope of this specific restriction report should be directed to Defra
5. HSE is Great Britain's independent regulator for workplace health and safety. HSE also has the role as the Agency for UK REACH under the UK REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals) Regulations.

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## **HSE to lead investigation into death of George Gilbey**

The investigation into the death of George Gilbey is now being led by the Health and Safety Executive (HSE).

George, 40, was working in Shoeburyness, Essex on 27 March 2024, when he fell to his death.

The involvement of Essex Police has now concluded. HSE will now lead the criminal investigation.

HSE inspector Natalie Prince said: "We have been a part of this inquiry from the outset, and we will continue to thoroughly investigate George's tragic death as the lead agency.

"This will aim to establish if there have been any breaches of health and safety law.

"We are in regular contact with George's family and our thoughts remain with them at this time."

### **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.
  2. Further details on the latest [HSE news releases](#) is available.
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# HSE issues urgent offshore gangway safety notice

- Power failures and control errors cause gangways to retract without warning, risking fatal falls
- Oil and gas operators to review gangway systems or stop operations
- Safety measures required before workers can safely use motion compensated gangways

The Health and Safety Executive (HSE) has issued a [safety notice](#) today (8 August) to highlight the risks of potentially fatal gangway accidents to offshore workers.

Serious risks have been identified where motion compensated gangways retract without warning due to power failures or control system errors. This puts workers at risk of falling from height, being struck by moving parts, or suffering serious injuries including death.

HSE is calling on operators in oil and gas, and renewable energy sectors to review their gangway arrangements. Any gangways that cannot provide sufficient warning before automatic retraction must be taken out of service until proper safety controls are installed.

Howard Harte, Operations Manager (Offshore Regulation) at the Health and Safety Executive, said: “Despite a previous safety alert in 2024, and the publication of industry good practice, we have become aware that gangways that provide insufficient warning before auto-retraction are still being used in the offshore oil and gas and renewables industry.

“This safety notice addresses continuing incidents where gangway failures have resulted in unexpected retraction without adequate warning to operators or personnel crossing between platforms. Workers have been left unable to move to safety or brace for sudden movement when systems fail.”

Under the requirements, dutyholders must conduct technical risk assessments of all automatic gangway functions. Control systems must only allow auto-retraction when personnel are confirmed safe. The use of gangway operators to manually override automatic retractions requires rigorous risk assessment.

The HSE emphasises that adequate warning systems must provide advance notice before dangerous events occur.

Howard added: “A warning by definition is advanced notice that a potentially dangerous event is about to occur. The purpose of the warning is to enable persons to make themselves safe before the event occurs. Audible and/or visual alarms that are triggered at the same time the gangway retracts are not considered to provide adequate warning to enable workers to reach safety.”

Dutyholders must review their gangway design, including the testing that has

been carried out of all automatic functions. They should carry out a suitable and sufficient technical risk assessment to understand all operational states of the control system under which the gangway may auto-retract, including that the control system will only result in auto-retraction if personnel are not at risk. Use of gangway operators to override auto-retractions should be rigorously risk assessed.

The safety notice can be viewed at:

<https://www.hse.gov.uk/safetybulletins/motion-compensated-gangways-auto-retraction.htm>

Further guidance on offshore health and safety law, risk assessment and equipment safety is available on the HSE website:

- [Offshore health and safety law](#)
- [Managing risks and risk assessment at work](#)
- [Equipment and machinery safety](#)

#### **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. HSE issued a previous safety notice relating to the risk of serious injury from motion compensated gangways in 2024 – [HSE Safety Notice ED02-2024 Risk of serious injury from motion compensated gangways](#).
3. Relevant legal documents:
  - [The Health and Safety at Work etc. Act 1974 \(Application outside Great Britain\) Order 2013](#)
  - The Health and Safety at Work etc. Act 1974. [General duties of employers to their employees](#) and [General duties of employers and self-employed to persons other than their employees](#)
  - [The Management of Health and Safety at Work Regulations 1999. Regulation 3: Risk Assessment](#)
  - The Provision and Use of Work Equipment Regulations 1998. Regulation 4: [Suitability of work equipment](#), Regulation 5: [Maintenance](#), Regulation 6: [Inspection](#) and Regulation 11: [Dangerous parts of machinery](#)
  - [The Work at Height Regulations 2005](#)

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## **[Waste firm fined after worker crushed](#)**

## by excavator

A County Durham waste management company has been fined after a young employee was run over by an excavator.

Farm XS (Northern) Limited, based in Barnard Castle, was sentenced after an incident on 29 January 2024 that left the 24-year-old with serious injuries.

The employee was only in his second week of employment at the Staindrop Road site when he was struck from behind by an excavator and run over. He suffered fractures to both feet.



XS Farm excavators and waste pile

An investigation by the Health and Safety Executive (HSE) found that the company had failed to ensure a safe system of work was in place. The 24-year-old was working on a waste pile near moving vehicles with no physical separation between them. There was no risk assessment or system of work to protect pedestrians from vehicle movements.

HSE guidance clearly states that pedestrians and vehicles should be segregated when waste is being manually sorted. By law, employers must ensure traffic routes can be used without risking the safety of workers nearby. Guidance is available at [hse.gov.uk](https://www.hse.gov.uk) – [Transport movements – HSE](#)



XS Farm waste piles

The case against Farm XS (Northern) Limited, Shaw Bank, Staindrop Road, Barnard Castle, County Durham, DL12 8TD, was heard at Teesside Magistrates' Court on Tuesday 5 August 2025. The company pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. It was fined £4,000 and ordered to pay £4,285 in costs.

After the hearing, HSE inspector Richard McMullen said:

"The outcome could have been much worse. But the failures that day meant a worker received serious injuries.

"This incident was easily avoidable by implementing control measures and safe practices to ensure that workers were not put at risk from moving vehicles, including clear segregation and safe refuges.

"This should be a reminder to the waste industry of the need to consider workplace transport risks and to introduce appropriate control measures to separate vehicles and pedestrians."

This prosecution was brought by HSE enforcement lawyer Iain Jordan and paralegal officer Helen Jacob.

#### 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. [hse.gov.uk](https://www.hse.gov.uk)
2. More about the legislation referred to in this case can be found at: [legislation.gov.uk](https://www.legislation.gov.uk)
3. HSE news releases are available at: [hse.gov.uk](https://www.hse.gov.uk)
4. Guidance for working safely with vehicles can be found at: [Workplace transport – HSE](https://www.hse.gov.uk/workplace-transport)

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## Council fined after failures led to care home death

- Man was able to leave care home undetected in early hours of morning.
- Search involved police, coastguard and firefighters.
- Doors at the home were not alarmed or protected.

A local authority has been fined after the death of a patient who went missing from a care home on the Isle of Barra.

Western Isles Council pled guilty to a charge under the Health and Safety at Work Act following the death of a 69-year-old man at St Brendan's Care Home in Castlebay.

Allan MacLeod, who had been diagnosed with Dementia, had been a resident at the home – one of five operated by the council throughout the Western Isles – for around six months at the time of his death. In the early hours of 9 March 2024, he had been able to leave his bedroom without the knowledge of staff and was only found around four hours after going missing. He died a short time later in hospital.

Mr MacLeod had been placed in the home in October 2023 to allow him to be nearer a relative who stayed on Barra. In his first month at the home, staff observed him and determined patterns in his behaviour and how they could best assist him. He was able to go on regular road trips around the island with his family.

On 8 March, having been settled in bed around 9pm, hourly checks were carried out to ensure his wellbeing, but at 2am on 9 March, his bed was unoccupied, and he could not be accounted for after a search of the home.

To avoid being observed by staff, he had exited the home via the only door that was not alarmed and was ten metres from his bedroom. Police Scotland were alerted and a search initiated.

Local Coastguard, RNLI and firefighters were called out to assist in the search and at around 6am, the Coastguard helicopter detected a heat signature near the home on the patio of a residential property.

Mr MacLeod was found with facial injuries consistent with falling. He was transferred to hospital, but despite the efforts of medical staff, he died an hour later.

An investigation by the Health and Safety Executive (HSE) determined that he had made several previous attempts to leave the home. Any measures that staff had taken to mitigate this, by fitting an electronic tag to his clothing that indicated his whereabouts had been defeated by Mr Macleod having removed it.

A risk assessment carried out in December 2023 indicated that Mr MacLeod would remove a tag if he located it, therefore staff required to be vigilant to this behaviour. It was only after his death that the home introduced a regime of half hourly checks on residents. Arrangements had already been made to install keypad entry systems on all doors, but this work had not been completed before Mr MacLeod's death.

Western Isles Council, of Sandwick Road, Stornoway, pleaded guilty to breaching Sections 31 and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The council was fined £80,000 at Lochmaddy Sheriff Court on 6 August 2025.

HSE inspector Ashley Fallis said: "This was a tragic and preventable death.

"The council should have made sure the home had stronger measures in place

with Mr MacLeod's risks already known and assessed.

"Although changes have since been made, they came too late to prevent his death."

**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](#).