

# A North East plastic packaging manufacturing company fined after an employee suffered serious injuries

A plastic packaging manufacturer has been fined after an accident at its site resulted in an employee suffering multiple fractures to their pelvis and legs.

Peterlee Magistrates' Court heard that, on 12 September 2017, the employee of Sirap UK Ltd, of Salters Lane, Sedgfield was operating a forklift truck near to a row of Flexible Intermediate Bulk Containers (FIBCs). FIBCs are more commonly known as bulk bags or dumpy bags and are used in many industries, including construction and manufacturing, to transport products or materials.



The Health and Safety Executive (HSE) investigation found that the FIBCs were stacked in an unsafe manner at a height of approximately 2.2 metres. The employee reversed the forklift truck and it caught one of the lower FIBCs causing it to tear and spill its contents. The employee attempted to repair the tear but the top FIBC, weighing about 1 tonne, fell and struck the employee.

HSE considered arrangements at the site, for the everyday use such as storage, reuse and repair of FIBCs, created a risk of injury.

Sirap UK Limited, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974 and Regulation 10(4) of the Work at Height

Regulations 2005; and was fined £150,000 and ordered to pay £1061.47 costs.

After the hearing, HSE inspector Clare Maltby said: “There are many companies using this type of container and they should note that the use of FIBCs requires safe stacking formations and safe systems for reuse and repair. Had the company adopted the correct standards this worker would not have been injured”.

#### 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](http://hse.gov.uk)<sup>[1]</sup>
2. More about the legislation referred to in this case can be found at:

[www.legislation.gov.uk/](http://www.legislation.gov.uk/)<sup>[2]</sup>

HSE news releases are available at <http://press.hse.gov.uk>

The post [A North East plastic packaging manufacturing company fined after an employee suffered serious injuries](#) appeared first on [HSE Media Centre](#).

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## [Industrial roof and cladding company fined after self-employed workers suffer burn injuries](#)

A company has been fined after failing protect its self-employed workers from the risk of a cable strike explosion or electrocution whilst carrying out repairs at AVL Powertrain, Viggen Way, Coventry.

Coventry Magistrates’ Court heard that on 28 November 2018, two self-employed workers received serious burns to their hands whilst using a drill to attach a pre-fabricated cowling to a cable tray. The incident occurred when one of the fixings went into a cable, striking one of the phases and causing an explosion.



An investigation by the Health and Safety Executive (HSE) found that Unique Envelope Façade Solution Limited's risk assessments and method statements did not consider the risk of drilling into cable trays containing live cables, isolating the electrics to complete work, or other methods of fixing which did not involve drilling.

Unique Envelope Façade Solutions Limited of Winster Grove Industrial Estate, Great Barr, Birmingham pleaded guilty to breaching Regulation 4(3) of the Electricity at Work Regulations 1989. The company was fined £20,160 and ordered to pay costs of £1,178, as well as a victim surcharge of £170.

Speaking after the case, HSE inspector Gareth Langston said: "This incident demonstrated the importance of the role of those preparing the job. The company overlooked the 415V 3 phase cabling they were drilling in towards. A cable strike, even at this voltage, can cause a major explosion.

"This incident has left two men with long-lasting burn injuries and they are now unable to work for a long time."

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## [Director sentenced after his brother's fatal fall from height](#)

A solar panel company and its director have been sentenced after his brother's fatal fall from height.

Worcester Crown Court heard that on 9 December 2015, during installation of solar panels on the roof of a barn at Manor Farm, Orleton, Hereford, Stephen Webb fell approximately seven metres through a fragile roof ridge panel to the ground below suffering fatal injuries.



An investigation by the Health and Safety Executive (HSE) found that no measures were in place to prevent falls from the roof or through the roof.

Light Power Grp Limited of Keady Orchards, Boraston Bank, Tenbury Wells, Worcestershire pleaded guilty to breaching Regulation 4 (1) of the Work at Height Regulations 2005. The company has been fined £80,000 with a victim surcharge of £120.

The director of Light Power Grp Limited, Michael John Webb of Keady Orchards, Boraston Bank, Tenbury Wells, Worcestershire pleaded guilty to breaching Regulation 4 (1) of The Work at Height Regulations 2005. He was given a 12-month community order to carry out 200 hours of unpaid work and ordered to pay costs of £15,000 with a victim surcharge of £60.

Speaking after the hearing HSE inspector James Lucas said:

“There are no winners in this tragic case. Falls from height remain one of the most common causes of work-related fatalities in this country and the risks associated with working at height are well known.”

“This tragic incident led to the avoidable death of a young man, who had only that year become a father. This death could easily have been prevented if the

company and director had acted to identify and manage the risks involved, and to put a safe system of work in place.”

Further information about safe techniques can be found at:  
<http://www.hse.gov.uk/construction/safetytopics/roofwork.htm>

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3. HSE news releases are available at <http://press.hse.gov.uk><sup>[3]</sup>

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## [Company fined after worker became entangled on a manual lathe](#)

An engineering company, has been fined for safety breaches after an employee suffered serious injuries to his left arm and hand whilst operating a manual lathe.

Sheffield Magistrates’ Court heard that, on 26 February 2018, a 61-year-old worker of Wincobank Fabrication and Engineering Ltd (WFE) was polishing a solid chrome bar on the lathe using hand-held emery cloth when his left hand and arm became entangled with the rotating bar on the company site on Sheffield Road, Rotherham. As a result, his left index and middle fingers were amputated and his wrist and two bones in his left forearm were broken. The worker required surgery and metal plates were inserted into his arm.



An investigation by the Health and Safety Executive (HSE) found that the hand application of emery cloth on manual lathes was custom and practice amongst lathe operators at WFE. The risk assessment in place for the machine had not considered the risks from polishing, or identified suitable control measures for operation of the lathe. At the time of the incident, the injured party had been employed at WFE for just under one month and had not received adequate instruction and training on how to polish safely. The investigation also found that he was wearing gloves at the time of the incident which significantly increases the risk of entanglement. HSE guidance clearly states that hand polishing on a manual lathe with emery cloth is strictly prohibited.

Wincobank Fabrication and Engineering Ltd of The Ickles, Sheffield Road Rotherham pleaded guilty to breaching Section 2 (1) of the Health & Safety at Work etc Act 1974. The company has been fined £33,500 and ordered to pay costs of £1,426.

After the hearing, HSE inspector Lois Taylor commented: "Serious accidents involving the use of emery cloth on metalworking lathes occur every year.

"Such accidents could easily be avoided by properly assessing the risks to determine whether the use of emery cloth on these machines can be eliminated completely. Where this is not practicable, then a safe method should be used for its application.

This incident could so easily have been avoided by simply carrying out correct control measures and safe working practices"

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website that is the best guide to doing it the right way:

3. [www.hse.gov.uk/pubns/eis2.pdf](http://www.hse.gov.uk/pubns/eis2.pdf)

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## [Painting and decorating employer sentenced after worker is seriously injured falling from height](#)

A Northamptonshire painting and decorating employer has been sentenced after an employee sustained serious, life changing injuries after falling from height.

Wellingborough Magistrates' Court heard that, on 7 August 2018, an employee of Ian Ramsay was severely injured when he fell from height whilst installing a roof ladder on a pitched roof at a property in Mawsley, Northamptonshire. The fall resulted in the employee being permanently paralysed from the chest down. The homeowners hired Mr Ramsay to paint the exterior windows and soffit boards of their property, including the painting of dormer windows within their roof. The employee was in the process of setting up ladders to access the dormer windows when he fell from height.

An investigation by the Health and Safety Executive (HSE) found that the incident could have been prevented if the work at height hierarchy had been followed in the planning process and if appropriate equipment had been provided to employees, such as fully compliant scaffolding. The risk assessment should have identified that this work was not short duration and that the use of ladders was not appropriate.

Ian Ramsay of Padmans Close, Mawsley, Northamptonshire, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. He was sentenced to a 12-month community order, 160 hours of unpaid work and ordered to pay costs of £2,124.28 with a surcharge of £85.

Speaking after the hearing, HSE inspector Rachel Grant said "Employers and

those in control of any work at height activity must make sure work is properly planned, supervised and carried out by competent people.

“This includes using the right type of equipment for working at height. In this instance, the painting of the soffits and windows was not short duration work and should have been done from appropriate work platforms. Ladders were not the appropriate equipment.”

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