

Home workers must be protected like any other employee

- Employers have the same health and safety duties for home workers as for office-based staff
- Key risk areas to consider include stress and mental health, display screen equipment, and working environment
- Free guidance is available to help employers meet their responsibilities.

Over a third of workers in Great Britain now work remotely or in hybrid arrangements, but not all employers realise health and safety responsibilities apply equally at home as in the workplace.

The Health and Safety Executive (HSE), Britain's national workplace regulator, is reminding employers of the need to assess the risks for all home workers.

Home and hybrid working is now found across almost every sector and business size. Latest figures from the Office for National Statistics show that in January 2026, 38 percent of workers in Great Britain were working remotely or in some kind of hybrid arrangement (25% hybrid and 13% working fully remotely).

HSE is advising employers to pay particular attention to three essential areas: stress and mental health, the safe use of display screen equipment (DSE), and the working environment – including accidents, emergencies, and lone working. This is a legal duty, not optional guidance.

Barbara Hockey, from HSE Engagement and Policy Division, said: "Working from home can deliver benefits to both employers and employees but with more than three in ten workers now working remotely or in a hybrid arrangement, it's important that employers understand their responsibilities.

"The good news for bosses is you don't need to physically visit someone's home to fulfil your duties, most of the time, the risks are low and the steps to manage them are straightforward, and HSE provides free guidance to support you.

"Practically, this means managers keeping in regular contact with their teams, talking openly about workloads and training needs, and making sure people aren't under pressure to work outside their normal working hours.

"It also means having simple conversations about the physical environment by asking staff to visually check that their equipment is safe and not damaged, keeping work areas clear of trailing wires or obstructions, and making sure everyone knows what to do in an emergency.

Free, practical resources are available at [hse.gov.uk](https://www.hse.gov.uk) to help businesses of all sizes carry out home-working risk assessments and meet their obligations.

Notes to editors

1. [The Health and Safety Executive \(HSE\)](https://www.hse.gov.uk) is Britain's national regulator for workplace health and safety. We are dedicated to protecting people & places and helping everyone lead safer and healthier lives.
2. Further details on the [latest HSE news releases](https://www.hse.gov.uk/press-releases) are available at [press.hse.gov.uk](https://www.hse.gov.uk/press)
3. 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 relevant sentencing councils provides guidelines for health and safety offences for [England](https://www.hse.gov.uk/england) and [Scotland](https://www.hse.gov.uk/scotland) on their websites.
4. For more detail on the Office for National statistics, see: [Public opinions and social trends, Great Britain: working arrangements – Office for National Statistics](https://www.hse.gov.uk/public-opinions-and-social-trends)
5. Further information and free guidance for employers on homeworking health and safety responsibilities is available at [hse.gov.uk](https://www.hse.gov.uk).

[Father of three electrocuted at Devon biogas site as two companies ignored safety warnings](#)

– Carl Parsons, 34, was killed and Luke Madavan was seriously injured when a cherry picker struck an 11,000-volt overhead powerline

– Two companies have been fined following the death of Carl Parsons and life-changing injuries to a colleague at a Devon biogas site.

– HSE investigation found that Willand O&M had been advised to relocate the overhead powerline nine months before the incident but failed to act

Two companies have been fined after an employee was killed and a colleague left with life-altering injuries when a cherrypicker collided with an overhead powerline.

Willand O&M Ltd and New Wave Marine Ltd were sentenced at Exeter Crown Court on 3 March 2026 following an incident on 1 June 2020 at the Willand Biogas site, Hide Market Road, Cullompton, in Devon. Carl Parsons, 34, was electrocuted and colleague Luke Madavan, AGE, was left with life-changing injuries

Described by his family as funny, loving, kind and a fantastic father, Carl

Parsons was a loving husband, son, brother and uncle, well-loved by everyone who knew him. He left behind a wife and three children.

The court heard that New Wave Marine had been contracted by Willand O&M to lift the lid of a biodigester and stir a crust blockage that had accumulated inside the tank. During this work, a cherry picker operated by New Wave Marine struck an overhead powerline. The electrical current passed through the metal basket, fatally electrocuting Carl Parsons and causing a serious electric shock to Luke Madavan.

An HSE investigation found that Willand O&M had been advised by their principal contractor and Western Power Distribution to relocate the overhead powerline. Doing so would have eliminated the risk of contact during both the build and foreseeable future maintenance. Willand O&M failed to act on this advice and put no adequate control measures in place, such as height restrictors on cherry pickers or restricted work areas. Supervision, monitoring and site induction were also found to be poor.

New Wave Marine's risk assessment was found to be neither suitable nor sufficient. The company also lacked formal training provision and adequate supervision for the work being carried out.

HSE has guidance on [working safely near overhead electricity power lines](#) and recognised industry guidance is also available via [Look Out Look Up](#). The guidance advises to plan and manage work near electric overhead power lines so that risks from accidental contact or close proximity to the lines are adequately controlled.

Willand O&M Ltd of Cleave Farm, Station Road, Willand, Cullompton, Devon, pleaded guilty to an offence under Regulation 3(1)(a) of the Electricity at Work Regulations 1989 by virtue of Regulation 14, having failed to ensure that persons carrying out work at the site were not working on or near a live conductor without reasonable and suitable precautions in place to prevent injury. The company was fined £51,000 and ordered to pay prosecution costs of £28,467.

New Wave Marine Ltd pleaded guilty to offences under Regulation 3(1) of the Management of Health and Safety at Work Regulations 1999 and Regulation 4(1) of the Work at Height Regulations 2005. The company was fined £30,000 with prosecution costs of £8,000.

HSE Inspector Nicole Buchanan said: "Working underneath overhead powerlines is inherently unsafe and these risks should be eliminated wherever possible. There is a risk that workers operating equipment could either make direct contact with the electrical source or be exposed to electricity arcing over several metres and travelling through the basket. The electricity network will provide guidance and assist in moving lines or burying them underground to prevent incidents. Companies should always seek competent health and safety advice and ensure their staff are adequately trained.

"The death of Mr Carl Parsons and the injuries to Mr Madavan were entirely avoidable and I hope that this case will serve as a lesson to others who try

to avoid costs by working near overhead powerlines. I express my deepest sympathy to those who witnessed the incident, to Carl's family, his wife, and especially to his three children, and to Mr Madavan; and I thank them for their cooperation throughout the investigation."

The prosecution was brought by HSE enforcement lawyer Alan Hughes, HSE advocate Sam Jones, and paralegal Helen Jacobs.

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 [Overhead power lines – 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](#).

[Care home fined after resident choked to death on meal](#)

- Resident died after being served food that did not meet his documented swallowing requirements.
- HSE investigation found a failure in the system of work for preparing and serving modified meals.
- Thomas Telford had a well-documented history of dysphagia and was at high risk of choking.

A care home company has been fined after a resident choked to death on food that had not been prepared in accordance with his dietary requirements at a Selkirk care home.

Selkirk Sheriff Court heard that on 25 May 2023, Thomas Telford, known as Barry, aged 86, choked during lunch at Riverside Healthcare Centre, Bridge Street, Selkirk. Mr Telford had been a resident at the home since 9 May 2023, having been admitted directly from Kelso Community Hospital.

He had a complex medical and a well-documented history of dysphagia – difficulty swallowing – that had been identified as far back as November 2019.

Mr Telford had been assessed as requiring a Level 5 (minced and moist) diet under the International Dysphagia Diet Standardisation Initiative (IDDSI), meaning all food should be minced into small moist pieces no greater than 15mm in length and 4mm wide. His care plan also required that he be supervised at mealtimes due to his tendency to overfill his mouth and eat quickly, and he had been identified as being at high risk of choking.

At lunchtime on 25 May 2023, Mr Telford was served a meal of beef, mashed potato and cabbage. The beef served to him had not been prepared in accordance with his Level 5 dietary requirements. A carer supervising the dining room noticed his lips turning blue and immediately raised the alarm. Backslaps and abdominal thrusts were administered, and an ambulance was called. He was pronounced dead at Borders General Hospital at 14:00 hours.

An investigation by the Health and Safety Executive (HSE) found that Riverside Care Limited had failed to ensure a sufficiently robust system of work for the preparation and serving of texture-modified meals. Whilst the home operated a broadly suitable system of serving either normal or modified meals, and staff had received training on dysphagia and the IDDSI framework, that system had failed on the day in question. As a result, Mr Telford was served food that was not safe for him to consume.

Employers providing care to individuals with swallowing difficulties must ensure that systems for preparing and serving texture-modified diets are sufficiently robust to guarantee that only appropriate food is served to those who require it, at every mealtime without exception.

HSE provides extensive [guidance](#) intended to help those providing and managing care homes – to give them a better understanding of the real risks and how to manage them effectively.

On Tuesday 3 March 2026, Riverside Care Limited, of Bridge Street, Selkirk, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £16,000 at Selkirk Sheriff Court.

After the hearing, HSE Inspector Robbie Morrison, said:

“Mr Telford’s need for a texture-modified diet was well documented and well known to those caring for him. He had a history of dysphagia and had been clearly identified as being at high risk of choking.

“Employers have a duty to ensure that the systems they put in place to protect the people in their care are robust enough to work consistently and without fail. In this case, that system was not sufficiently robust, and the consequences were fatal.

“This was a tragic and entirely preventable death. We hope this case serves as a reminder to all care providers of their responsibility to ensure that residents with complex dietary needs receive only food that is safe for them.”

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. Guidance on health and safety in care homes can be found here: [Health and safety in care homes – 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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[Immingham metal fabrication company sentenced after seven workers develop vibration-related illnesses](#)

- Seven employees reported with vibration-related conditions including nerve damage and finger blanching
- Workers described daily life impacts including numbness at night and inability to grip
- Company failed to risk assess vibration exposure or provide health surveillance and training

A metal fabrication company based at Immingham Docks in North East Lincolnshire has been sentenced after pleading guilty to exposing multiple employees to vibration risks at work.

HSE became aware in June 2024 of three reports of vibration-related illness among employees of Drury Engineering Services Ltd. An investigation was opened and an Improvement Notice served on the company to control the ongoing risk.

The notice was served because the company had failed to reduce employees' vibration exposure to as low a level as reasonably practicable through organisational and technical measures.

During the investigation, inspectors identified a further three employees who met the threshold for reporting to HSE due to vibration-related illness. A seventh report was made by the company later that year.

Employees told inspectors the illness was affecting their daily lives. Some experienced finger blanching during simple household tasks such as mowing the lawn. Others were kept awake at night by numbness in their hands, while some

described being unable to grip and suffering nerve damage.

Drury Engineering Services Ltd has been operating at Immingham Docks since 2000. A new health and safety manager was appointed in June 2022 and began work to address issues with the company's vibration management system, but by this point employees had already been significantly exposed to vibration risks.

The investigation found that the company had failed to:

- suitably and sufficiently assess the risks from vibration exposure
- implement organisational and technical measures to reduce vibration exposure to as low a level as reasonably practicable
- place employees who were exposed to significant levels of vibration under a suitable health surveillance system
- provide employees with suitable and sufficient information, instruction and training

HSE provides extensive guidance on the risk of [vibration](#) in the workplace and the need to ensure that the risk is properly assessed, and appropriate measures implemented to control exposure from the risk of vibration.

Drury Engineering Services Ltd, of East Riverside, Immingham Dock, Immingham, North East Lincolnshire, pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc. Act 1974. The company was fined £44,000 and ordered to pay £8,061.70 in costs at Grimsby Magistrates' Court on 26 February 2026.

HSE Principal Inspector Chris Tilley said: "Today's fine should send a clear message that both HSE and the courts take seriously the failure to manage employees' exposure to vibration.

"HSE will not hesitate to take action against companies that do not do all they should to keep people healthy and safe."

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

Notes to Editors

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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](#) are available.
4. Guidance on Vibration at Work can be found here: [Vibration – 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 in England can be found [here](#) and those for Scotland [here](#).

[Police force fined after student officer hit by car on Christmas Eve](#)

- The student officer had been responding to a traffic collision.
- HSE investigation found West Mercia Police failed to manage risks.
- Force failed to provide suitable information and training to its officers.

A police force has been fined after one of its officers was hit by a passing car while responding to a traffic collision on Christmas Eve.

The 22-year-old was a student officer working for West Mercia Police when the incident happened on 24 December 2023. The officer had been responding to the traffic collision in Bridgnorth, Shropshire. That collision occurred on a single carriageway road that had no street lighting and where the national speed limit for the road was 60 mph.

The officer had been stood on a bend, managing traffic at the scene when he was hit by a passing car. He sustained life-threatening and life-changing injuries.

An investigation by the Health and Safety Executive (HSE) found that West Mercia Police failed to do all that was reasonably practicable to manage the risks arising from or in connection with traffic collisions. The force's risk assessments were not suitable and sufficient and it failed to provide adequate equipment for safely responding to traffic collisions.

There was also a lack of suitable information, instruction and training for its officers. As a result, employees and members of the public were exposed to unnecessary risks.

In June 2021, the National Police Chiefs' Council (NPCC) sent all police forces across the UK a series of recommendation reports which provided relevant advice explaining how to implement road safety recommendations following an officer and staff safety review report.

The Office of Chief Constable West Mercia Police, Headquarters, Hindlip Hall, Hindlip, Worcester, pleaded guilty to breaching Sections 2(1) and 3(1) of the Health and Safety at Work etc. Act 1974. The force was fined £85,800 and ordered to pay £9,402 in costs at Birmingham Magistrates Court on 20 February 2026.

HSE Inspector Keeley Eves said:

“We recognise that police officers inevitably face significant and serious dangers as part of their normal work. The nature of policing is such that even where all reasonably practicable steps have been taken to minimise the risks, there may still be a significant risk to those engaged in such work.

“However, police officers should not be exposed to unnecessary risks while keeping the public safe.

“In this case, West Mercia Police failed to implement all reasonably practicable measures to minimise risks to its employees and members of the public in connection with road traffic collisions.

“Tragically, this resulted in a student police officer sustaining life changing injuries.

“After the incident, the force implemented significant changes, which included revisions to risk assessments, policies, procedures, equipment and training.

“These measures should have been in place prior to the incident.”

This HSE prosecution was brought by enforcement lawyer Edward Parton and paralegal officer Lynne Thomas.

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: [Managing risks and risk assessment at work: Overview – 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](#).