APPEAL COURT, HIGH COURT OF JUSTICIARY

Lord Mackay of Drumadoon
Lord Menzies
Lady Dorrian

[2012] HCJAC 11
Appeal No: XC 478/11

XC479/11

OPINION OF THE COURT

delivered by THE HONOURABLE LADY DORRIAN

in

NOTE OF APPEAL AGAINST SENTENCE

by

SCOTTISH SEA FARMS LTD

First Appellants;

and

LOGAN INGLIS LTD

Second Appellants;

against

HER MAJESTY'S ADVOCATE

Respondent:

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First Appellants: Gray, Q.C.; Biggart Baillie LLP
Second Appellants: Dickson, Solicitor Advocate; Anderson Strathern LLP
Respondent: Hughes, Advocate Depute; Crown Agent

26 January 2012

[1] On 31 May 2011, before the Sheriff at Oban, each of the appellant companies pled guilty, by way of Section 76 indictment, to separate charges of contravening Sections 2 and 33(1)(a) of the Health & Safety at Work Act 1974. Both charges arise out of an incident which took place on a barge moored at a sea farm

operated by the first appellants on Loch Creran on 11 May 2009. The barge is used as a store for fish feed, which is kept on deck in containers. Below the deck are eleven separate confined chambers. On the centre of the deck is a hydraulic crane with hydraulic and electrical cabling which runs below the deck. Access to below deck and the aforementioned chambers is by way of eleven sealed hatches, each bolted down by twenty bolts over a rubber watertight seal.

[2] On 7 May 2009, a problem had been identified with the hydraulic crane. Employees of the first appellants, Campbell Files and Robert McDonald, the site manager, spoke to Arthur Raikes, an engineer in the employment of the second appellants, which had done work for the first appellants in the past. From the discussions between the three men, the problem was thought to be a burst hydraulic pipe below deck. The three men realised that they would need below deck access to investigate the problem.

[3] The three men attended on the barge on 11 May, where they were joined by other employees of the first appellants, including, Maarten Den Heijer. Mr MacDonald, Mr Files and Mr Den Heijer opened a hatch at the middle of the stern of the barge and two of them entered the chamber without incident. Having failed to identify the problem with the crane's hydraulics there, Mr MacDonald, Mr Files and Mr Raikes decided to open another hatch closer to the crane. A hissing noise was heard when the hatch was opened and it was agreed to leave the hatch open for fifteen or twenty minutes to vent. After that period, Mr Files climbed down into the chamber closely followed by Mr Raikes. As soon as Mr Files reached the bottom of the chamber, about 8-10 feet below deck, he began to feel very disorientated and started to lapse in and out of consciousness. Mr Raikes, who had felt dizzy and short of breath as soon as he descended the ladder into the chamber, immediately climbed back onto the deck. Looking back into the chamber he saw that Mr Files had passed out and reported this to Mr McDonald. Mr McDonald went to retrieve a respirator, before proceeding to descend into the chamber to attempt a rescue. He reached Mr Files and lifted him from the water into a sitting position, giving a thumbs up signal to those above him. He was then seen to sit down in a corner whereupon he stopped responding to the calls of those on deck. His head had slumped forward. It is estimated that he was only at the bottom of the chamber for ten seconds before he collapsed. On seeing Mr MacDonald collapse, Mr Den Heijer, another employee of the first appellants, fetched a length of rope and descended into the chamber. He collapsed as soon as he reached the bottom of the ladder. Emergency services were alerted and paramedics and fire and rescue services attended at the barge. Fire and rescue teams wearing suitable breathing apparatus entered the chamber. Mr Den Heijer, who appeared to be dead, was lifted out first. Campbell Files, who was responsive and trying to speak, was lifted out next, followed by Robert McDonald. Resuscitation attempts on Maarten Den Heijer and Robert McDonald were unsuccessful. Fortunately Mr Files survived.

[4] An investigation measured the oxygen level in the below deck compartment at 13%, compared to a normal concentration in the air of 20.9%. The low level was caused by the oxidation of the steel walls of the tank. A relatively small percentage reduction of oxygen in the air can lead to impaired mental ability. The effects are extremely rapid and there will generally be no warning to alert the senses. Low oxygen concentrations of 16% or less can lead to unconsciousness and death. The three men succumbed to the lack of oxygen in the chamber and this led to the death of both Mr MacDonald and Mr Den Heijer.

[5] Working in confined spaces is considered to be hazardous and there are specific regulations governing such work. A confined space can generally be described as having the following characteristics:

- Severely limited natural ventilation
- Capacity to accumulate or contain hazardous atmosphere
- Exits that are not readily accessible
- A design not meant for continuous occupation

The chambers below deck on the barge in Loch Creran fulfil this criteria and are therefore confined spaces. Prior to this incident, no employee of either company had required to go below deck on the barge at Loch Creran.

[6] The charge against the first appellants was that on 11 May 2009, in relation to the barge moored at the sea farm operated by them on Loch Creran they (a) failed to make a suitable and sufficient assessment of the risks involved to the health and safety of their employees and, in particular, failed to identify the presence of confined spaces on their barge and the risks associated with confined spaces, including depleted oxygen levels; (b) failed to provide information, instruction and training to ensure the health and safety of their employees in relation to working in and identifying confined spaces and the risks associated therewith; and (c) failed to provide plant and a system of work to ensure the health and safety of their employees in relation to confined spaces and rescue procedures. The charge libelled that, as a consequence thereof, their employee Campbell Files entered a confined space where he lost consciousness due to depleted oxygen levels and was thus injured and exposed to risk of death; and that thereafter their employees Robert McDonald and Maarten Den Heijer entered the said confined space in an attempt to effect a rescue whereby they died as a result of the depleted oxygen levels.

[7] So far as the second appellants are concerned, the charge against them is that, in relation to the operation being carried out on the first appellants' barge, they (a) failed to make a suitable and sufficient assessment of the risk to health and safety of Arthur Raikes from the presence of confined spaces on the barge and (b) failed to provide information, instruction, training and supervision as was necessary to

ensure so far as reasonably practicable that their employees were able to identify confined spaces and the health and safety risks associated therewith, as a consequence of which Arthur Raikes entered a confined space and was exposed to risk of death.

[8] The facts outlined above were contained in an agreed written narrative which was placed before the court. In addition, the narrative recorded the opinion of the Health and Safety Executive that, considering the nature of their working environment, the first appellants had a good health and safety record overall and clearly took the issue of health and safety seriously. Since 2004 they had contracted a private company MENTOR, to assist them with meeting their health and safety obligations. It was agreed that in general, the level of health and safety training and information provided by Scottish Sea Farms to their employees was of a high standard. Scottish Sea Farms have been actively involved with a trade orientated health and safety forum, Scotland Marine Safety Committee, since 2005. Training and guidance has now been given to all employees, and employees have been instructed never to enter a confined space during the course of their work. The narrative recorded that:

> "The problem in this case was that neither Scottish Sea Farms either independently or through MENTOR recognised that there were confined spaces on the Loch Creran barge or indeed any of their barges. In the aftermath of this tragedy, a full survey of all their barges was undertaken. This revealed the presence of additional confined spaces on other barges. Having overlooked that there were confined spaces on their barges, Scottish Sea Farms did not thereafter risk assess the dangers inherently associated with working in confined spaces. Had a risk assessment identified confined spaces, policies and procedures could have been put in place which would have prevented employees undertaking any work in them."

[9] The narrative noted that the second appellants, Logan Inglis Limited, also used the services of an outside agency for health and safety advice and training, IMS Scotland Ltd. They focused health and safety training and advice on the activities within their own company premises where there were no confined spaces. Following this incident, they put their field engineers through confined space awareness training and have since withdrawn from undertaking any work involving confined spaces.

[10] In mitigation before the Sheriff the solicitor for Scottish Sea Farms Ltd relied on the company's previous good health and safety record, their lack of previous convictions, the acknowledgement that their health and safety training was generally of a high standard, their ready acceptance of liability, and the remedial measures taken by them. Considerable support had been given by the company to the families of the deceased and to those employees who had been affected by their deaths in the aftermath of the incident. It was explained that the company had a turnover of £93,968,000 and a gross profit

of £11,031,000.

[11] Before the Sheriff the solicitor for the second appellants, Logan Inglis Limited, was anxious to differentiate the level of culpability between the two companies. The second appellants were not charged with any responsibility for the deaths. They had no responsibility for health and safety on the barge. Moreover, they had a responsible attitude to health and safety and since 2003 had employed external health and safety advisors. They had been given incorrect advice by these advisors. Following this incident they had withdrawn from undertaking any work in confined spaces. The company was established in 2000 and by 2009 it employed 35 people. At the time of the plea, that number had decreased to 26 as a result of adverse economic conditions. The company had been significantly affected by the downturn in public sector work, but were attempting to meet business needs in difficult trading conditions. The solicitor for the second appellants also relied on a lack of previous convictions, the isolated nature of the incident, the lack of deliberation, their subsequent actings and their ready admission of responsibility.

[12] The submissions, summarised above, were set out in writing and supplemented by oral submissions before the sheriff. He was referred to *HMA* v *Discovery Homes (Scotland) Ltd and Another* [2010] HCJAC 47; *HMA* v *Munro & Sons (Highland) Ltd* 2009 SCCR 265 and the Sentencing Guidelines Council's *Definitive Guideline on Corporate Manslaughter and Health and Safety Offences Causing Death*. In his report the Sheriff states that, when sentencing he particularly had in mind the criteria referred to in *HMA* v *Munro,* namely that the sentencing judge should bear in mind the gravity of the offence, any aggravating or mitigating features, the ability of the accused to pay a fine, the policy underlying the section of the Act, under which the prosecution was brought, and the public interest. The public interest is explained in para [34] of the opinion of the court in *HMA v Munro* as being that the accused be punished for its culpable failure to pay due regard for safety and for the consequence of that failure. The Sheriff explained his approach thus:

> "In sentencing I accepted that neither company had previous convictions for analogous offences and that both had pled guilty at the earliest opportunity. I accepted that the culpability of Logan Inglis, in relation to their failures and statutory duty were less than those of Scottish Sea Farms and that there was a substantial difference in their ability to pay a fine. I accepted that their failures in duty were in no way linked to the deaths. I considered the respective failures of both companies to be very serious."

[13] Taking account of these matters, as well as the first appellants' ability to pay a fine, specifically their annual turnover in excess of £93,000,000, he considered an appropriate level of fine for Scottish Sea

Farms to be £900,000. This was discounted to £600,000 to reflect their early plea. So far as Logan Inglis Ltd are concerned the Sheriff states that he took care not to attach blame to them for the deaths and had in mind that distinction between the two companies when imposing sentence. As to that company's ability to pay a fine, he noted a turnover of £2,778,681 and payments to directors amounting to £89,000. Taking this factor into account and the gravity of the offence, as well as the mitigating factors outlined on behalf of the company, he imposed a fine of £40,000, discounted from £60,000 to reflect the plea of guilty.

[14] On behalf of the first appellants, it was argued that the sentence was excessive and that the Sheriff had failed to take into account a number of mitigating factors. In particular, he had failed to give any, or sufficient, weight to the following factors: the lack of previous convictions; the thoroughly responsible attitude to health and safety and good safety record of the company; the indication of a responsible approach shown by the employment of MENTOR; their involvement in the Scottish Marine Safety Committee which was a further indication of their positive approach to health and safety; that the level of health and safety training provided by them was generally of a high standard; that they had fully co-operated with the police and Health and Safety Executive and taken responsible steps to remedy defects in their system of working; and that the company was genuine in its remorse and had not sought to evade responsibility.

[15] These mitigating factors are all highlighted in paragraph 8 of the Sentencing Guidelines Council's Definitive Guideline referred to above but, it was submitted, the sheriff failed to have sufficient regard to them. It was also suggested that the Sheriff failed to have sufficient regard to the absence of the kind of aggravating factors often seen in health and safety prosecutions, namely a breach forming part of a course of conduct, as opposed to an isolated incident, or which occurred against a background of a failure to heed warnings or which involved the deliberate disregard of duties or occurred with a view to making a profit. Senior counsel also relied on what were referred to as the "unusual circumstances" in which the accident took place. It was said to be a factor in mitigation that the accident occurred in an area of the barge to which employees had never prior to the accident had cause to visit, that the use of confined spaces was not something which the company expected to encounter in the course of its activities and that against that background the existence of the area in question as a confined space in respect of which a risk assessment would require to have been undertaken was not detected by either the appellant company or its specialist advisors.

[16] On behalf of the second appellants it was argued by their solicitor advocate that the Sheriff had imposed an excessive sentence by failing to take into account numerous mitigating factors, in particular: that the second appellants had no responsibility for the deaths or for the injury to Campbell Files; that they

had an unblemished safety record and no history of non-compliance; that they had a responsible attitude to health and safety; that this was an isolated incident; that they had taken a positive decision no longer to undertake work in confined spaces; that they had engaged external health and safety advisors who had given them incorrect advice; and their prompt admission of responsibility.

[17] It was also argued that the sheriff had paid insufficient regard to the financial circumstances of the second appellants. The fine imposed took insufficient account of the fact that the appellants were an important employer in the Cumbernauld area, faced with difficult trading conditions, which had persisted since the time of sentence. The second appellants were doing their best to avoid making employees redundant. Although there had been a 35% reduction in turnover they had only reduced staff by 25%. The company had made a net profit in the year to April 2009. There had been a net loss of £25,413 in the year to April 2010, although it was accepted that this was after a payment of salary to directors. The solicitor advocate for the second appellants accepted the proposition from *R* v *Balfour Beatty Rail Infrastructure Ltd* [2007] 1 Crim App Reports (S) 65 that:

> "knowledge that breach of this duty can result in a fine of sufficient size to impact on shareholders will provide a powerful incentive for management to comply with this duty".

However, he reminded us that the court in that case went on to say:

> "This is not to say that the fine must always be large enough to effect dividends or share price".

The second appellants continued to operate on a tight budget, having already made redundancies. Although they may make a small profit, anticipated to be less than £10,000, for the year to April 2011, future redundancies could not be ruled out. To fund an extra £40,000 to pay the fine imposed would not be easy at a time when obtaining any bank loan was difficult and the company already had a floating charge over its assets. The fine should be a punishment but it should not bring the company to its knees.

Discussion

[18] The relevant considerations in sentencing in a case of this kind were considered in *HMA* v *Munro* in which the court endorsed the approach taken by the Court of Appeal in England in *R* v *Balfour Beatty Rail Infrastructure Services Ltd.* The principles which are relevant to the present case are as follows:

> (a) where death occurs as an consequence of the breach, that is an aggravating feature, multiple deaths being viewed even more seriously than single deaths.
>
> (b) a breach with a view to profit is a serious aggravation.
>
> (c) the degree of risk and extent of the danger and in particular whether this was an isolated

incident or one continued over a period.

(d) mitigation will include (1) a prompt admission of responsibility; (2) steps taken to remedy deficiencies; and (3) a good safety record.

(e) the resources of the offender and the effect of a fine on its business are important. Any fine should reflect the means of the offender but could not be said to stand in any specific proportion to turnover or profit. The objective of the fine should be to achieve a safe environment for the public and bring that message home, not only to those who manage a corporate offender, but also to those who own it as shareholders.

[19] This approach is reflected in the Definitive Guideline of the Sentencing Guidelines Council in England on Corporate Manslaughter and Health & Safety Offences Causing Death, which lists factors likely to aggravate or mitigate such offences. Aggravating factors include: (a) more than one death, or very grave personal injury in addition to death; (b) failure to heed warnings or advice; (c) cost-cutting at the expense of safety; (d) deliberate failure to obtain or comply with relevant licences; and (e) injury to vulnerable persons. Mitigating factors include: (a) a prompt acceptance of responsibility; (b) a high level of co-operation with the investigation, beyond that which will always be expected; (c) genuine efforts to remedy the defect; (d) a good health and safety record; (e) a responsible attitude to health and safety, such as the commissioning of expert advice or the consultation of employees or others affected by the organisation's activities. The guidelines have statutory effect only for England and Wales but may be noticed for the purposes of sentencing similar cases in Scotland. Although they apply to cases involving death, and so are not strictly relevant to the position of the second appellants, many of the aggravating or mitigating factors which may apply in such cases will also be relevant to consideration of offenders in the position of the second appellants. It will be seen that of the aggravating factors referred to in *Munro* and in the Definitive Guideline, only one applies in the case of the first appellants, namely the deaths of Mr McDonald and Mr Den Heijer, and the injury to Mr Files. Otherwise, none of the aggravating factors applies. None of the aggravating factors applies to the second appellants, and all of the mitigating factors apply to both appellants.

[20] Considering the facts of the case, we are in agreement with senior counsel for the first appellants that the circumstances could be described as an honest failure by a company with a good record and a responsible attitude towards Health and Safety. Having said that, we do not consider that the circumstances in which such a failure arose, can properly be described as "unusual". Being unforeseen is not the same as being either unforeseeable or unusual. As senior counsel for the first appellants required to concede, to anyone applying their mind to the need for routine repair of the hydraulic crane, it would have

been obvious that access to cabling in a confined space below deck might be required. In that regard, no explanation was forthcoming as why neither the second appellants nor their health and safety experts, MENTOR, had failed to identify, what Mr MacDonald, Mr Files and Mr Raikes had realised would be necessary when on 7 May 2009 they discussed the repair of the crane.

[21] We are nevertheless satisfied that the Sheriff erred in his approach to sentence in this case. It is true that he indicates that the principles in *Munro* were in his mind when sentencing, but he does not explain how he applied those principles when he determined the fines he imposed. As far as the first appellants are concerned, the Sheriff took account of the serious aggravating factor of the deaths of Mr McDonald and Mr Den Heijer, and of the serious risk of death to which Mr Files was exposed. He also stresses that as far as the second appellants are concerned he took care not to attach any blame to them for the deaths of Mr MacDonald and Mr Den Heijer. He acknowledges that neither appellant had previous convictions and that both had pled guilty at the earliest opportunity. However, in respect of neither appellant does the Sheriff make clear what account he took of the absence of any other aggravating factors nor what effect this had on his choice of sentence. Nor does he mention the presence of the other mitigating factors noted above, such as the appellants having made genuine efforts to rectify the defects in their systems of work; their good health and safety records; and their commissioning of outside experts to advise on health and safety. In these circumstances it is unclear whether the sheriff took proper account either of the presence of genuine mitigatory factors or of the absence of other aggravating ones. For these reasons, we have reached the conclusion that we should reconsider the fines imposed by the Sheriff in the light of all the relevant factors.

[22] In our opinion the breach of statutory duty to which the first appellants pled guilty was a very serious one. It was a significant cause of the deaths of two of their employees and exposed a third employee to the risk of death and is aggravated by those deaths. It may well be that the circumstances which give rise to that breach of statutory duty involve a honest mistake by a company with a good record of, and a responsible attitude towards, health and safety. However, such mitigating factors do not detract from the fact that neither the first appellants nor their health and safety advisers (who were engaged back in 2004) can offer any understandable explanation as to how and why they failed to identify the risk posed by the presence of the confined spaces in the barge in Loch Creran (or for that matter other barges operated by the first appellants in Scotland). The first appellants are, of course, only being prosecuted for the events on 11 May 2009. However the fact that neither they nor MENTOR identified the presence of any confined spaces on any of the first appellants' barges at forty sites does not, in our opinion, reduce the gravity of the first appellants' breach of statutory duty. On the contrary it merely serves to accentuate the absence of

any cogent explanation as to why the confined spaces on the barge in Loch Creran, and the need for below deck access during any repair of the hydraulic crane on that barge, were not identified prior to 11 May 2009.

[23] During the course of his submissions, senior counsel for the first appellants recognised that a significant financial penalty was appropriate and did not advance any submission that the first appellants did not have the financial resources to pay the fine that had been imposed. Against that background and taking account of the absence of any previous convictions; the first appellants' health and safety record and the Health and Safety Executive's assessment of that record; the first appellant's full co-operation with investigation of the accident; the steps the first appellants have taken to rectify the defects in their system of work; and the first appellants' general remorse, we take the view that the starting point of £900,000 adopted by the Sheriff was excessive. In our opinion a more appropriate figure is £500,000, which would adequately reflect the gravity of the charge and meet the public interest. We reduce that figure by one-third to a fine of £333,335 on account of the plea of guilty. That level of deduction is appropriate following on a plea of guilty to a section 76 indictment.

[24] Turning to the position of the second appellants, much of what we have said about the manner in which the Sheriff dealt with first appellants is applicable to them. The second appellants have no previous convictions. For a variety of reasons, the offence to which the second appellants pled guilty is a less serious one. The second appellants' employee Mr Raikes was working on a barge owned and operated by the first defenders. Whilst the second appellants are responsible for the risk of death to which Mr Raikes was exposed, their breach of statutory duty was not aggravated by the deaths of Mr Macdonald and Mr Den Heijer. Moreover, the financial standing of the second appellants is of a very different nature to that of the first appellants.

[25] The Definitive Guideline of the Sentencing Guidelines Council makes it clear that when a sentencing judge is determining the fine to impose "the effect on the employment of the innocent may be relevant", as will " whether the fine will have the effect of putting the defendant out of business" (see Part C, para 19). On the basis of the information placed before the court as to the state of the second appellants' turnover and financial resources, we are not persuaded that the imposition of a fine of £40,000 is likely to put the company out of business. However, it could well increase the risk of redundancy already faced by their employees. Furthermore in the present economic climate those who are made redundant are liable to experience considerable difficulty in gaining alternative employment. As we have indicated, the impact on the continued employment of employees is a factor of relevance in determining a fine to be imposed on their employer. Against that background, and having regard to all the other mitigating factors on which the

second appellants are entitled to rely, we intend to allow their appeal and reduce the fine to one of £20,000, which we calculate from a starting point of £30,000 subject to a reduction of one-third on account of the plea of guilty.