Neutral Citation No: [2026] NICC 3	*Ref:*	**[2026] NICC 3**
	ICOS No:	**25/075487**
Judgment: approved by the court for handing down (subject to editorial corrections)*	*Delivered:*	**19/02/2026**

IN THE CROWN COURT IN NORTHERN IRELAND
SITTING AT LAGANSIDE COURTHOUSE

THE KING

v

TOBERMORE CONCRETE PRODUCTS LIMITED

HHJ McCORMICK KC

Introduction

[1] Mr Colin Thomas was employed by the defendant company. Tragically, he died in an incident which occurred at his workplace during his nightshift shortly after 1am on 26 April 2023. The defendant company was arraigned on 28 November 2025. David Henderson, its Managing Director, entered a guilty plea to the single count on the Indictment, namely, failing as an employer to ensure the health, safety and welfare of employees contrary to Articles 4(1) and 31(1)(a) of the Health and Safety at Work (NI) Order 1978 on 26 April 2023.

[2] Today the court will sentence the company for that offending. Inevitably, the court will focus on the company and the circumstances which led to the tragic death of Mr Thomas. However, the deceased and his bereaved family will always remain at the heart of this criminal justice process.

[3] I am told that Mr Thomas was a very much-loved husband, brother and brother-in-law, uncle, nephew and cousin. The court has received Victim Impact Statements (VIS) from Mr Thomas' wife, Karen Thomas, and his sister, Sarah Lowe Thomas. In previous hearings, the court expressed its profound sympathy to Mrs Thomas and other members of the bereaved family. I have read the VIS carefully. The circumstances of Mr Thomas' death have made the bereavement very public. I thank Mrs Thomas and Mrs Lowe Thomas for sharing the personal details of their loss, anger, grief and concerns to which I will return in due course.

Background

[4] Tobermore Concrete Products Ltd manufactures and supplies a range of pre-cast concrete products to the markets in UK and Ireland. It has approximately four hundred employees, many of whom are drawn from the same locality in which Mr and Mrs Thomas made their home. Nine separate factories operate independently of each other within the plant at the village which gives the business its name.

[5] At the time of the incident with which this court is concerned, Mr David Henderson was the Managing Director (MD) and Mr Glenn Robinson was the General Manager and Executive Chairman of the Board of the Company. Subsequently Mr Robinson was appointed Chief Executive Officer (CEO) and now co-chairs the Senior Leadership Team with Mr Henderson, MD.

[6] Gareth Stewart, the General Manager, was the designated Health and Safety/Compliance Officer in 2023. He was subsequently appointed to the position of Health and Safety and Environmental Manager, (HSEM)

[7] Historically, employees were actively engaged in health and safety processes and structures in the plants. 'Representatives of Employee Safety', known as "ROES" are appointed from each shift in each factory.

The incident

[8] The deceased, Colin Thomas age 55, was employed by Tobermore on a full-time basis from 2 June 2014. He was working as a production leader in the factory known as HESS 1 during the night shift on 26 April 2023 and was also the night shift ROES.

[9] There are four parts to the HESS 1 plant: the wet-line, the dry line, the finger car zone and the little finger car zone. On 26 April 2023, the production Supervisor, Arnold McLees instructed Colin Thomas to carry out several cleaning duties within HESS 1 plant. Mr Thomas was Liam O'Donnell's Team Leader. Mr Thomas relayed to Mr O'Donnell the jobs which had to be done after they started their shift at 6pm on 25 April 2023. Initially, they spent a few hours filling buffer racks with emptied boards. Then they were tasked to perform a deep cleaning of the plant, particularly around the wet-line and main machine house windows. According to Mr McDonnell this was a job that they had done many times before.

[10] When the fatal incident occurred, Mr Thomas was cleaning the pit area under a vertical chain conveyor on the dry-line. In order to do so, he had entered the pit which is approximately 52cm deep. An industrial vacuum cleaner was to be used to remove the dust build up.

[11] Mr O'Donnell has told HSE that Mr Thomas entered the pit by Gate 4 on the perimeter fence fixed around the plant. Gate 4 was fitted with a safety interlock. He

instructed Mr O'Donnell to place the vacuum cleaner close to the dry-line so that he, the deceased, could vacuum the pit area from where he was positioned beside the lowerator.

[12] Mr Thomas entered the pit area while Mr O'Donnell was engaged in moving the vacuum cleaner. Mr Thomas was in the pit below the lowerator machine. Mr O'Donnell told the investigators, "Because I was moving the hoover I didn't see Colin entering the area and I just assumed he had isolated the machines and locked them out as is normal practice … I had been looking at the hoses or something close around the area and then I heard the latch conveyor move and Colin screamed."

[13] Mr O'Donnell was the sole witness albeit he did not see the incident directly. During the investigation by HSE, Mr O'Donnell recounted what he did as soon as he became aware of the calamity which, according to the CCTV, occurred at 1.12.42 am. "I ran to the emergency pull cord to stop the latch conveyor moving again. I then leaned in to check on Colin at the step area but he was unresponsive and possibly unconscious. I then ran outside and rang Arnold McLees to tell him Colin was trapped and I needed help.'

[14] Tragically, Mr Thomas was indeed trapped between the conveyor and the legs of the machine. After calling Mr McLees, who was the night shift supervisor, Mr O'Donnell returned to Mr Thomas who was unresponsive and could not be freed. Mr McLees arrived at 1.15.56 am and called the Production Manager, Thomas Shiels. He arrived at 1.24.01 am, immediately operated the controls of the machine to move the latch conveyor and freed Mr Thomas from the machine. By analysing the CCTV timings which have been available to the prosecution, the defence timeline indicates that Mr Shiels called the emergency services at 1.24.03 am, almost 12 minutes after the incident occurred.

[15] While Mr Shiels proceeded to the entrance to meet the emergency services and bring them to Mr Thomas, Mr McLees called another first-aider. In vain, CPR was administered to Mr Thomas. No pulse was detected. Despite the attention of the members of the emergency services who arrived on site at 1.38.41 am, it became clear that Mr Thomas had sustained fatal crush injuries to his torso and he was pronounced dead at the scene.

[16] I have been told and I accept that Mr Thomas' colleagues did all that they could to save him. He was a popular, well-known member of the Tobermore Concrete Community and his family has had a long relationship with Tobermore. This terrible tragedy was a harrowing experience for his peers. There is no evidence to suggest that had his colleagues taken any alternative steps, Mr Thomas could have been saved.

[17] Post-mortem examination established the cause of death to be compression of the chest and associated rib fractures and coronary atheroma-left ventricular hypertrophy was present.

HSENI investigation

[18] HSENI Operational Inspectors Sean Keogh and Brian Price were on call and were made aware of the incident at 02:42 and 07:10 respectively. They attended at the scene at 05:05 and 8:45am respectively on the 26 April 2023. So did PSNI Mapping and photography officers. HSENI commenced their investigation without delay. At 13:37 that afternoon, HSENI served a Prohibition Notice on the Company. This Notice at P123 of the documentary exhibits outlined the risks of entrapment and/or crushing in dangerous moving parts of the HESS 1 line that were not adequately controlled by the interlock devices.

[19] The Company complied with the HSENI Notice. Pending the installation of two sets of light sensitive safety barrier (like those in HESS 2, 3 and 4,) the Company was asked to change its interlocking gates within HESS 1 so that when a gate opened, the entirety of the manufacturing operation ceased. Once the light sensitive safety barriers were installed, HSENI permitted Tobermore to revert to the pre-accident arrangements in relation to interlocking gates. The court notes what the defendant company says about light-sensitive barriers not being required by European standards until 2003; and further, that when the standard changed prospectively in 2003, no direction issued to require factories installed before 2003 to alter their arrangements.

[20] During the investigation, Mr O'Donnell was asked about the cleaning operation which was ongoing when Mr Thomas was killed. Mr O'Donnell was interviewed by HSE and his witness statements dated 02.06.23 and 08.06.23 are found at Pages 1 and 3 of the depositions. He stated that the cleaning of the wet-line and dry-line had been done many times previously and the pit on the dry-line was cleaned regularly 'maybe monthly.' On Mr O'Donnell's account, cleaning methods varied. He told the HSE:

> "I had done this job before but I would do it from outside the machinery by feeding the vacuum hose under the fence and into the pit. It's easier this way than going inside the machine. I have seen Colin clean the pit the way he did that night on previous occasions."

[21] Tobermore produced a pre-incident risk assessment, 'HESS 1 (Dry Line) and HESS 1 (Wet Line)', a record of assessments which were carried out by Gareth Stewart. When interviewed, Mr Glenn Robinson confirmed on behalf of the Company:

(i) That there was no specific method or risk assessment in relation to cleaning activities.

(ii) The risk assessment for HESS 1 applied to all activities, dealing with risks such as dust, isolation and lockout and entrapment.

(iii) The isolation and lockout handbook makes it clear that prior to any cleaning or maintenance, "all the power within the designated area must be disabled … operator to ensure isolation and lockout procedure was being used."

[22] The Company also produced a PUWER risk assessment dated 16/4/22. This relates to the Provision and Use of Work Equipment Regulations (Northern Ireland) 1999.

[23] The PUWER assessment stated:

> "Training is suitable and sufficient, operators receive supervision from production manager, team leader and Health and Safety. Isolation lock out booklets have been communicated to all staff and followed up by competency assessments."

[24] Both Mr Thomas and Mr O'Donnell had been trained on these procedures for all areas of HESS 1.

[25] The HESS 1 plant had several safety features designed to ensure operators are not exposed to dangerous moving parts of the machine. These included:

(i) fixed guarding and interlocking gates; and

(ii) safety sensors which, when activated, stop movement of a particular part of the machine.

[26] However, neither the risk assessment, nor the PUWER risk assessment, nor the "Isolation and Lockout Handbook" nor the training documentation specify which part of the machine is isolated by each of the interlocked gates.

[27] Nor do those documents state where in the process each isolation ends.

[28] Nor are the location and function of the safety sensors documented.

[29] In the course of the plea in mitigation, the defendant company submitted that the deceased and Mr O'Donnell were being proactive in deciding to clean the lowerator although it was not part of their scheduled task that shift. Had the power been isolated from all the machinery within the dryline (of which the lowerator is one part) before commencing any relevant cleaning task, the dryline would have been disabled completely and they would have been protected from any risk of injury.

[30] However, it seems that the plant was in 'automatic' mode and that isolation had not taken place. No issue was taken with the submissions on behalf of HSENI that it is believed that a sensor beam was broken by Mr Thomas during cleaning. In

this combination of circumstances, the horizontal latch conveyor moved, crushing Mr Thomas between the moving conveyor and a fixed part of the machine.

[31] The HSENI investigation identified additional control measures which were available to the Company and were in use elsewhere in the Tobermore plants, but which had not been implemented on HESS 1:

(i) Elsewhere, in order to comply with PUWER, safety sensors were installed to prevent employees gaining access to dangerous moving parts when travelling inside the HESS line from one area to another. HESS 1 was not fitted with this technology prior to the incident. In that respect, the employer simply relied on training, information and instruction of employees to ensure their health and safety and welfare at work.

(ii) Mr Thomas accessed the lowerator area via Gate 4. When interviewed under caution on 30.05.24, Mr Glenn Robinson, then General Manager, confirmed this gate would isolate the finger cart only and that the lowerator and latch conveyor would not have been isolated.

[32] The HSE investigation was not confined to events on 26.04.23. It is noteworthy that CCTV footage for a period of three months prior to and including the incident was reviewed by the HSENI. It showed various operators breaching the Company's internal safety systems in a number of ways including the following lapses:

(i) Entering a hazard area without lock out procedures being followed;

(ii) Fixed guarding on the production line not secured in place allowing access to dangerous moving parts; operators were observed accessing the danger area via unsecured guarding; and

(iii) Operators intentionally resetting safety devices with colleagues in a danger zone behind fixed guarding and interlocking gates.

[33] By the time that Mr Robinson was interviewed on 30.05.24, he had already engaged with HSE by providing a pre-prepared statement covering a wide range of issues. Mr Robinson was authorised by the Managing Director, David Henderson, to furnish that statement covering a wide range of issues. That undated document, (which is Exhibit 16 and lies at Page 286 of the documentary exhibits) states (at paragraph 20):

> "The CCTV footage that has been provided to me demonstrates that by the time of the accident, practices within HESS 1 had crept in which neither Gareth Stewart nor management were aware … I want to stress that the Company fully accepts, particularly having seen the CCTV footage, that it is an accident that ought to have been

> avoided and that the practices demonstrated by the footage ought not to have been occurring. The Company has redoubled its efforts following this accident to ensure that nothing like this recurs …"

[34] He continued at the mid-point of his paragraph 35 (located at P294 of the documentary exhibits):

> "The Company's failure was one of supervision of Colin and the other operatives as plainly they had allowed dangerous habits to develop. In making this point the Company is not seeking to deflect from its own obligations. It was always the Company's responsibility to ensure that everyone worked safely on the plant."

[35] In paragraph 56 of his pre-prepared statement (at Exh P298,) Mr Robinson focussed on the fact that the dry-line moved while Colin Thomas was cleaning it and observed:

> "It inevitably means they had not carried out the isolation and lock out procedures properly…."

[36] The last sentence of paragraph 57 of Mr Robinson's statement reads:

> "Had that primary and essential step been taken, the dry-line would have been disabled completely, thereby protecting them from any risk of injury."

[37] The court has been told that the Managing Director personally checked all the minutes of meetings of the Health and Safety Committee as it was then constituted for a period of two years prior to Mr Thomas' death. He reported that he found no record that deficient practices in regard to securing guards or isolating plant had been brought to the attention of the Safety Committee through any source.

[38] Paragraph 72 of Mr Robinson's pre-prepared statement to HSE stated (at P303 of the documentary exhibits:

> "The Company accepts that it has failed to take all reasonable steps to ensure the safety of its employees. It has failed to supervise the activities of operatives to ensure that they adhered to their instruction and training."

The defendant detailed a matrix of remedial steps

[39] Post incident, new signage was placed on all interlocking Gates detailing what machinery is isolated when the Gate is open. (No such signage was in place in April 2023.)

[40] In response to the Prohibition Notice, the Company installed two light sensitive safety barriers within HESS 1 meaning that if a person enters an interlocked gate and travels to a part of the machine not controlled by that interlock, they will activate the safety sensor and power to the machine will stop. That provision is similar to the provision on the other HESS lines.

[41] At the time of the incident, the Safety Committee was chaired by the Health and Safety Officer. The Committee was not meeting as intended on a monthly basis nor were the Representatives of Employee Safety (ROES) attending regularly. The court was told that after Mr Thomas died, the Managing Director disbanded the committee and created a new Health and Safety Executive Committee which he chaired himself. It met weekly until Easter 2024 and liaised closely with HSENI in order to complete a full review of all health and safety practices across all of the factories. The defendant says that this Committee continues to meet on a monthly cycle to review the weekly safety report and any safety priorities.

[42] Safety team work processes are reviewed continually as are safety team service level agreements with all other departments.

[43] The Health and Safety and Environmental Team has expanded from three to five full-time members of staff. The team carries out weekly random safety checks throughout the company.

[44] One of the Night Shift Production Supervisors also undertakes additional health and safety advisory duties at night, carrying out an agreed schedule of workplace inspections and other safety-related duties.

[45] The Health and Safety team compiles a weekly health and safety report which updates Production Managers/ Supervisors and the Senior Leadership Team on compliance and key performance indicators related to Tobermore's safe systems. It reports on workplace inspections completed, scheduling / content / attendance at toolbox talks; records details of accidents and near misses.

[46] All documentation is stored on SharePoint and Production Managers/Supervisors have unlimited access to that material.

[47] There are weekly safety team spot checks of the dedicated cleaning teams.

[48] There are safety inspections of planned maintenance works.

[49] The company already had a bespoke health and safety employee compliance system known as OBBI. The company introduced OBBI software to record all checks

and corrective actions across the company. Each operative is required to complete a pre-work health and safety checklist before commencing work each day and any identified risks are addressed. Then Production Managers and Supervisors must complete the OBBI "end of shift safety checklist" whereby they report on the adequacy of and compliance with of all health and safety requirements throughout their shift.

[50] Reporting lines have changed. In addition to completing the OBBI end-of-shift-checklist, Nightshift Production Managers and Supervisors also complete a communication report which includes safety related checks and this report is emailed to the Works Manager and the Health and Safety and Environmental Manager.

[51] Since Mr Thomas died, all supervisory personnel within the factory are responsible for the creation of Health and Safety Hazard training documentation; this is no longer the responsibility of the Health and Safety and Environmental Manager alone. All Hazard Warning documents for each factory have been reviewed and operatives have been trained.

[52] The company has a whistleblowing policy and also conducts onsite supervision. The court has been told that the company expresses a reluctance to use CCTV to effectively monitor employees. However, the defendant submits that this investigation has demonstrated to operatives that the CCTV facility is a means of recording practices which may become of the subject of investigation.

[53] In 2025, the Company published a new edition of its Health and Safety Environmental and Quality Policy Handbook which was last updated in 2019. This handbook identifies and re-states the responsibilities of each employee.

[54] Following Mr Thomas' death, the role and responsibility of ROES was refined. The ROES responsibility is only carried out by the Team Leader of each shift. ROES have a number of responsibilities, including ensuring that staff under their control do not undertake a task for which they have not been trained.

[55] The Health and Safety and Environmental Manager creates, reviews and updates risk assessments for all activities and processes across the plant. After consultation, he ensures that relevant personnel are sufficiently trained in the risk assessment.

[56] A training programme ensures that a significant number of senior employees are achieving the Nebosh Health and Safety Qualification.

[57] Not only does Tobermore subscribe to the HSE Executive Bulletin but it took further steps to promote best practice. Tobermore's longterm partner Willis Consulting, (which already provided Health and Safety audits for Tobermore,) has contracted in a Health and Safety expert to give Tobermore additional monthly health and safety guidance and support.

[58] Individual safety padlocks were issued to every production operative, production manager and supervisor. All operatives have been instructed that padlocks must be applied before entering an interlocking gate. New signage has been placed on all interlocking gates to make clear to operatives when they can access through interlocking gates by applying a lock.

[59] Health and Safety Sampling across the site is more structured. The schedule for workplace inspection audit is informed by the assessment of risk across the plant and the Safety Team follows up corrective actions via the OBBI system.

[60] All head office operations staff complete a weekly safety checklist via the OBBI system.

[61] All staff will have annual refresher training including a health and safety component.

[62] All factory Isolation and Lockout booklets have been reviewed and all staff have been retrained.

[63] A new Traffic Management Team was established to review continuously traffic management across the sites.

Culpability, harm and risk

[64] The court notes that both the prosecution and defence have referred to the English 2016 Sentencing Guidelines when making submissions about culpability and harm and risk.

Culpability

[65] Medium category culpability cases are understood to be cases in which the defendant's operation has fallen short of the appropriate standard and high category cases are those where the operation fell far short of the appropriate standard. The prosecution and defence have submitted jointly that this case lies in the upper end of medium category culpability cases and the court indorses that assessment.

Harm

[66] The court has to assess the harm caused by the offending. Mrs Thomas' VIS sets out the many ways in which she is bereft. Their long and close relationship was in its fourth decade and she says they just fitted. She is surrounded by reminders of her late husband's absence from the life and home they built together, from their locality and community. Her bereavement reaches into every part of her life, isolating

her and taking a toll on her health and wellbeing; on the financial security and retirement she had planned with the deceased.

[67] Closely acquainted with the details of this awful event, she lives with a series of what-ifs and the horror of her husband's last minutes. She is grieved by the passage of time between Mr Thomas being trapped and the ambulance being called for: a window of 17 minutes, she has been told, albeit that the timing on Tobermore's CCTV indicates that emergency services were alerted within 12 minutes.

[68] Mrs Thomas worked for this employer for more than 30 years and the deceased was a fulltime employee for nearly a decade. Other relatives are also associated with Tobermore. Since Colin Thomas' death, the family's long-standing relationship with Tobermore has been disrupted on a number of counts which has simply added to this widow's distress. Clearly, no expression of sympathy or apology can fill the void in her life. She hopes that by sharing her experience, the wellbeing and safety of employees will be prioritised so that no other Tobermore family suffers in the way she has done.

[69] Mrs Lowe Thomas frequently relives the horror of the early morning phone call telling her that her brother was dead. Our sibling relationships are likely to be the longest of our lives and this sister describes a very close relationship. Her brother's death has severed a bond which cannot be replaced. Like her sister-in-law, Mrs Lowe Thomas is processing feelings of anger and helplessness and the host of what-ifs which might have led to a different outcome. She says, in terms, that if she and the rest of the family could be sure that no other Tobermore family would suffer as they have done, that would be her brother's legacy and their family might begin their healing.

[70] The court concludes that this is a case of high harm.

Risk

[71] The Company has no previous convictions but other incidents of concern were identified in the papers filed in court. Each of Mrs Thomas and Mrs Lowe Thomas have expressed concern for other employees. The court records that the defendant company co-operated by replying promptly to the court's enquiry about reports of other specific incidents which were raised by Mrs Thomas and which the court considers to be relevant to the assessment of risk.

[72] I have been told that this company is devastated by Colin Thomas' death; that he was a popular and industrious colleague and friend and everyone associated with Tobermore continues to be deeply affected by this incident and by Mr Thomas's tragic death. In these proceedings, the Company reiterated its condolences to Mr Thomas' family and loved ones.

[73] Tobermore cooperated fully with the HSENI investigation. It pleaded guilty at the first opportunity in circumstances where the offending had been admitted firstly in the pre-prepared statement and again in the after-caution interview of 30.05.24.

[74] The court's only sanction is the imposition of a fine which must be measured by reference to culpability and harm and risk, taking account of all other factors, including the defendant company's turnover and profitability.

[75] Tobermore is said to have an exemplary health and safety record. Until the incident in which Mr Thomas lost his life, Tobermore has never had a prohibition or improvement notice nor been the subject of any adverse finding from HSENI much less been prosecuted for a health and safety breach. Tobermore reports a history of low accident rates. I am told that its commitment to safety standards is demonstrated by disciplining 8, 13 and 16 employees for breaches in 2021, 2022 and 2023 respectively. The company says these considerations point towards a low risk of recurrence of this offending.

[76] Two specific allegations of near misses in the months before Mr Thomas' death are raised in the VIS made by Mrs Thomas. Similar concerns about two separate incidents were raised by text messages sent to HSE on 1.07.23 by a relative of the deceased. That person indicated that the first incident involved MM having a near-miss in Hess 2 during a nightshift. The second incident of near-miss involved NS and NP and was alleged to have occurred during day shift in Hess 1.

[77] These issues were raised with Glenn Robinson in his after-caution interview on 30.05.24 and Mr Robinson was given an opportunity for Tobermore to look into these allegations.

[78] He found that Tobermore had records about an incident in Hess 2 in which MM went through guards and a cuber nearly hit him. That incident had already been investigated by the H&S Officer in September 2022 and it emerged that MM had not been trained on the "Controlled Observations behind Guarding" procedure. The incident and subsequent actions were fully documented and an oversight in the training programme for MM was identified. Immediate corrective action was taken: MM was trained by the H&S officer. Moreover, as part of the firm's commitment to health and safety, that "Controlled Observations behind Guarding" procedure was removed in June 2023 and replaced by another process, namely "Permit to Work." Operators were made aware of the Permit to Work in the weekly Toolbox Talks. In short, the incident had already been logged, the issues addressed and remedial steps taken before HSE were alerted about the matter on 31.07.23.

[79] Mr Robinson made enquiries about was reported to have happened NS and NL in the second incident in Hess 1. The deceased's relative had characterised it as the exact same type of incident as the incident which took Mr Thomas' life.

[80] The court has read the defendant's solicitor's email to HSENI dated 28.11.24 reporting that Tobermore had not been made aware of such an incident before it had been raised by HSENI. In separate meetings, both operatives confirmed that the alleged unsafe practice did not occur and further, they expressed disappointment at the making of the allegations. The court was also told that Tobermore personnel had reviewed CCTV footage from Hess 1 for a period of about three months before Mr Thomas died. (It is noteworthy that this footage had already been provided to HSENI.) The solicitor advised HSENI, in terms, that Tobermore's review of that footage had brought them to conclude that no near-miss incident had occurred involving NS and NP. The HSE did not dispute that position and no contrary submission was made to the assertion that the allegation had been fully investigated.

[81] The prosecution has categorised the risk of harm at the upper end of low risk and the defence agreed with this categorisation. Taking account of all of the steps which have been taken by or on behalf of the defendant company since April 2023, the court agrees with that categorisation.

[82] There are no aggravating factors other than those which have already informed culpability, harm and risk.

[83] Mitigating factors include:

(i) the fact of early admissions via pre-prepared statement and admissions in interviews;

(ii) positive engagement throughout the investigation;

(iii) remedial steps taken at once;

(iv) documented commitment to continuous improvement in the area of health and safety,

(v) Tobermore's positive health and safety record.

[84] Tobermore is a very significant local employer. The Company's gross turnover over the last three years exceeds £80M. Its annual net profits exceed £10M.

[85] HSENI's review of CCTV footage for three months prior to Mr Thomas' death disclosed a matrix of breaches of the Company's internal safety systems, including operatives entering a hazard area without adhering to lock out procedures and accessing danger areas via unsecured guarding but the company continued to rely on training and information and instruction to ensure the safety of its employees, including the deceased.

[86] This court wishes the family of the deceased to know that the fine does not reflect the value of their loved one's life. It is the court's sanction for failing to ensure Mr Thomas' health, safety and welfare at work.

[87] Having taken account of culpability, harm and risk, this court has concluded that in all of the circumstances of this case, if convicted after trial, the starting point for the fine would be £250K. Taking account of the mitigating features in the case, that figure would reduce to £240K.

[88] The defendant company pleaded guilty. That figure of £240K will be reduced by a full third, reflecting the fact that the defendant company admitted its culpability from the outset, first in the pre-prepared statement and then in the after-caution interview. That brings the fine to £160K.