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Judgment: approved by the Court for handing down

*(subject to editorial corrections)**

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Bill No: 13/002266

IN THE CROWN COURT IN NORTHERN IRELAND

ANTRIM CROWN COURT
SITTING AT BELFAST

THE QUEEN

v

GEORGE BROWN

WEIR J

[1] George Brown, you have pleaded guilty to two counts of manslaughter and 19 counts under the Health and Safety at Work (NI) Order 1978. The counts, 21 in all, relate to failures by you or your employees in relation to gas installations at a total of 16 separate premises in the Portrush, Portstewart and Coleraine areas. It is now my duty to sentence you in respect of those offences.

[2] The most serious of those failures in its consequences relates to the installation by your business of a replacement gas boiler and flue at an apartment in a block at Tunnel Brae, Castlerock. In 2010 the apartment owner sought your advice about a persistent drip through the ceiling from part of the heating installation in the void above. You advised that she should replace it in its entirety and she accepted your advice and engaged you to provide the new system and carry out the work of installation. The work appears to have been carried out around the middle of March 2010 and you invoiced the owner for it on 23 March.

[3] In May 2010 the owner visited the property having first checked with you and been assured that the new system was working. In June she returned for an overnight stay and operated the boiler on its time switch mode. She became unwell during her stay but did not appreciate the cause. On returning home she consulted her doctor who diagnosed and commenced to treat her for vertigo.

[4] On 23 July 2010 the owner again stayed overnight at her apartment. Again she became unwell but managed to drive home and again consulted her doctor who told her to keep taking the tablets previously prescribed. In fact, with the benefit of hindsight, the true cause of her illness was carbon monoxide poisoning. Fortunately for her, the timer had switched the system off during the night or she might also have fatally succumbed to the poisonous gases.

[5] However, at the end of July 2010, a fatal consequence did ensue from the use of this new heating system. Three teenage boys had arranged to use the apartment for a few days to celebrate the end of their "A levels" and their plans for the future. They made use of the new heating system in the apartment and after their first night they felt unwell but put it down to something they had eaten. On the following night they again slept in the apartment but two of the boys could not be wakened by the third. His friends, Aaron Davidson and Neil McFerran had both died in their beds. Their friend was seriously ill and extremely fortunate to survive the experience.

[6] The new heating system immediately fell under suspicion as a possible cause of the deaths and an obvious defect was discovered in the void above the ceiling of the apartment. A pipe rose vertically from the outlet on the top of the boiler into the ceiling void where it made a right - angled turn into a pipe running horizontally to the outside wall. This turn was effected by means of a right - angled bend into which the horizontal and vertical sections of pipe required to be securely joined. When inspected it was obvious that the joint was not securely in place because the bend had become detached from the pipe because it had not been properly attached to the straight sections of pipe. No joint clamps were secured and no self-tapping screws had been inserted so as to secure the bend to the straight pipes. These necessary items were supplied by the manufacturer with the pipes and had only to be fitted and tightened, a simple task. They were not. As a result when the boiler was fired it discharged carbon monoxide at the defective joint into the ceiling void instead of venting it safely to the outside of the building.

[7] This omission was the crucial and immediate cause of the entirely avoidable deaths of the two boys. Sheer laziness was responsible. There were a number of other faults including a failure to convert the boiler to run on LPG (or bottled) gas instead of mains gas which may have been due to the fact that your workman had no qualification in LPG changeover installation and therefore ought not to have been working at it. There was also a failure to adjust the settings on the burner so as to ensure that excessive carbon monoxide was not produced. This requires the use of a specialised instrument known as a flue gas analyser. There is no evidence that such was used or indeed as to whether it was available on the job. If it was used it must have been used incompetently.

[8] When Miss McDermott QC made her submissions concerning the lack of self-tapping screws to secure the elbow joint in place she said that she was instructed that it was because too many of the supplied screws had been used elsewhere on the

pipework leaving none available for this joint. If that had been so then of course the system ought not to have been put into operation until additional screws had been obtained and inserted. No such screws were ever inserted in the months between March and July. However, when I examine the details of the other defective installations that came to light when customers reported that you had also done installation work for them following the publicity given to your firm's involvement in the fatal installation, I find that the omission of screws to secure joints and pipework was noted to have been a feature in five of those other cases together with an alarming litany of shoddy and unsafe workmanship generally. I therefore conclude that the absence of the requisite screws from the installation at Tunnel Brae was a common feature of the work done by your business. It is indeed fortunate, and perhaps the only slightly redeeming feature of this wholly tragic and avoidable disaster, that the publicity it has received may have saved other of your customers from death or serious injury as a result of your careless work. I hope that if these remarks are published by the media it will encourage any other of your former customers who have not already done so to engage a qualified, competent and careful engineer to check that their installations are safe because you appear to have exercised no control or supervision over your workmen to quality and safety assure the work that they did and that you were evidently quite happy to charge for. Your cavalier attitude to what you must have known was this most dangerous substance – in truth a silent killer – is impossible to comprehend and entirely reprehensible. You well knew the dangers yet you and your workmen chose to ignore them with wholly predictable fatal consequences.

[9] You are 52 years old, married with two grown up children, who have now moved away. Apart from one minor motoring matter you have a completely clear criminal record. I have noted that both the Probation Officer and Dr Maria O'Kane, Consultant Psychiatrist, consider you to be very remorseful for what has happened and very concerned by the suffering that the families of the boys have endured. You have closed what was a successful business built up over years and both you and your wife feel yourselves to be ostracised by your community as a result of these events. You say that you will never work again in the gas business and I am sure that that is a prudent decision for all concerned. I treat you as a man of hitherto blameless character who has permanently lost much as a result of the way you conducted your business and who will never be free of the consequences of your failures.

[10] I have also received and read with care several poignant victim impact statements provided by the families affected by this tragedy. They have been gravely and probably permanently affected by the loss and near loss of their boys and their feelings have again been sharply re-awakened in the period leading up to this trial. They have not been assisted by the long period taken by the prosecution and the HSE to bring this relatively straightforward matter into the court arena. No one reading the accounts of their experiences could fail to be moved by the severe and lasting effect upon them of this wholly avoidable tragedy.

[11] In relation to counts 1 and 2, those of manslaughter, there is a document agreed between senior counsel for the prosecution and for the defence that sets out the Basis of the Plea. I now set out the terms of that agreement and my approach to the facts for the purpose of this sentencing exercise is based upon those terms:

> "1. The Defendant undertook work to No 1 Tunnel Brae, Castlerock, in the course of March/April 2010 that involved the installation of a Vaillant gas boiler and flue system (by way of replacement of the existing boiler and flue system). The Defendant accepts that, as such, he owed a duty of care to the householder and to those lawfully using the premises to ensure that the boiler and flue system was properly installed and commissioned prior to the apartment being reused.
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> 2. The nature of the apartment was such that the flue design required a 90 degree bend in the flue section within the ceiling void of the apartment leading from the gas boiler. This required two sections of flue piping to be joined via an elbow joint. The joint is only properly performed if the various sections of piping overlap by 45mm and are held in place by the placing of a pipe band with screws tightened and the insertion of self-tapping screws to hold the pipes in place and to stop them from parting.
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> 3. Following the accident, the HSE investigation revealed that the vertical pipe was completely disconnected from the elbow joint where it met with the horizontal run. This was the source of the escape of carbon monoxide when the gas fire system was fired within the apartment.
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> 4. Though the evidence suggests that the piping was connected to the elbow joint at the time of installation, the height of the joint between the two sections of piping (now disconnected) was between 8mm and 10mm. Also, self-tapping screws were missing from the connecting pipe to the elbow joint.
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> 5. The Defendant accepted the contract to install and commission the boiler and he also procured the boiler and materials to be used. This particular

Vaillant boiler was designed and manufactured to run on natural gas. As the gas supply to the Apartment was from Liquid Petroleum Gas (LPG) the boiler required some modification to allow it to be converted to run on LPG rather than natural gas.

6. The Defendant asserts that all of the critical installation work was conducted at various times by [two employees] of the Defendant and on his direction. The Prosecution accepts that there is a reasonable possibility that this may be the case and that the Defendant falls to be sentenced on that basis.

7. Though [Workman A] had experience of gas boiler installations, was qualified to install, connect and commission a domestic natural gas boiler, and was a Gas Safe Registered Installation Engineer, he did not possess the necessary qualification to convert a domestic natural gas boiler to one run on Liquid Petroleum Gas [LPG]. Accordingly, at the time of the installation he should not have been involved in the connection and commissioning of the Vaillant LPG appliance.

8. [Workman B] was, at the relevant time an apprentice with no relevant qualifications.

9. It was the Defendant's obligation to ensure that a suitably qualified Installation Engineer carried out the work. If, as the Defendant asserts, the critical work relating to installation was performed by an unqualified employee, the Defendant ought not to have entrusted an unqualified person to carry out the connection or commissioning of the LPG boiler.

10. The Defendant asserts that he was not personally responsible for joining the piping to the elbow joint. The Prosecution has no evidence to the contrary and the Defendant falls to be sentenced on that basis.

11. The Defendant admits that he failed to ensure that the critical installation work was conducted by suitably qualified engineers.

12. In order to commission the boiler correctly it was necessary for the Installation Engineer to adjust the boiler's gas pressure and to set the carbon monoxide and carbon dioxide flue gas analysis ratio of the gas flue analyser to the correct settings. A failure to do so can result in incomplete combustion products producing high levels of carbon monoxide in the flue gases. The boiler was found to be incorrectly adjusted to run on LPG. Testing by Operatives from Vaillant in the aftermath of the incident showed that while high levels of carbon monoxide in the flue gases were present, the boiler was operating within its expected "overload" range. The high levels of carbon monoxide only became relevant to the cause of the death because of the flue becoming disconnected.

13. The Defendant admits that his failures constituted breaches of his duty to the householder and to all other lawful users of the property, including the deceased.

14. The Defendant admits that the breaches of duty were causative of the deaths of Neil McFerran and Aaron Davidson.

15. The Defendant admits that his breaches of duty amounted to gross negligence on his part, to the extent that his omissions amounted to a criminal act."

[12] The industry of Counsel has failed to produce any prior charge of manslaughter within this jurisdiction arising from the grossly negligent installation of a gas appliance. It is also the case that the range of culpability and therefore sentence for manslaughter ranges very considerably. In cases of corporate manslaughter the use of the guidance contained in the English Sentencing Council's "Corporate Manslaughter and Health and Safety Offences Causing Death" has been approved of in this jurisdiction. Patently the present case is not one of corporate manslaughter and Miss McDermott submitted that the guidelines therefore have no application to the present case. However, in R v Holton [2010] EWCA Crim 934, a court presided over by the Lord Chief Justice of England and Wales, the following passage appears at para 20:

> "The Court now also has the advantage of the recent Definitive Guidelines on Corporate Manslaughter and Health and Safety Offences Causing Death. Although this relates to organisations rather than individuals, and to financial penalties, it helpfully sets out at paras 6, 7 and 8 relevant factors affecting seriousness with examples of aggravating and mitigating circumstances."

I consider that the use of those particular provisions of the guidelines is of value in identifying relevant factors affecting seriousness and I have therefore considered them for the purposes of that evaluation.

[13] **How foreseeable was serious injury?**

The risk of injury or death was obvious. The dangers of carbon monoxide poisoning due to the escape of flue gases are well known, even by those not involved in the sale and installation of gas appliances.

How far short of the applicable standard did you fall?

The reports of the HSE and, importantly, of your own retained expert who in some respects is more critical than the HSE indicate that the work carried out was of an extremely poor standard in not one but several respects.

How common is this kind of breach in your organisation?

The defects discovered in the 16 of your jobs that have been examined indicate a pattern of similar shoddy installation and adjustment practice.

How far up the organisation did the breaches go?

This was a small business of which you were very much in day to day control. You have not been very forthcoming about who exactly did what at Tunnel Brae but the facts that you maintained no known commissioning documentation for any of your work, that you allowed an employee to work at a job involving an LPG conversion who was unqualified to do so and that the quality of the work as discovered on the 16 jobs was extremely poor all point to an absence of any, or any effective, oversight by you of the quality and safety of the work being carried out.

Was there more than one death?

There were, as we all well know, two deaths and a third was only by good fortune narrowly avoided.

[14] Turning to the factors set out in the guidelines that bear on mitigation:

Was there a prompt acceptance of responsibility?

Regrettably there was not. Attempts were made to blame the carpenter who replaced the ceiling panel through which the vertical section of flue passed for dislodging the joint when the joint had not been made secure in the first place and to place the bulk of the responsibility upon your employee. Notice of a "No Bill" application was given and then withdrawn and you then initially pleaded not guilty at arraignment to all counts.

Was there a high level of co-operation with the investigation beyond that which will always be expected?

Again the answer is no, your co-operation at interview was minimal. You were quite entitled in law to maintain that stance but in consequence you cannot receive credit for particular co-operation in the investigation.

[15] I have already pointed out that the guidelines regard the fact of more than one death as an aggravating feature. This is in keeping with the modern sentencing approach, both legislative and judicial, to attach more weight to the fatal consequences of a criminal act. I respectfully adopt the further observations of the English Court of Appeal at paragraph 19 of Holton's case in which a wall had collapsed killing a young worker:

> "Furthermore, in the sentencing process for homicide cases, including deaths on the road, there is now a greater emphasis to be placed on the fatal consequences of a criminal act. The Lord Chief Justice explained the reason for this in some detail in the recent case of Appleby (a case altogether different from the present); see particularly [13], and in relation to deaths on the road, [20]. It seems to us today that a similar consideration applies to cases of manslaughter by gross negligence in the workplace."

[16] I conclude that all the matters that I have mentioned in these sentencing remarks make this a most serious case. My starting point for sentence is one of six years' imprisonment but I will allow credit for your plea of guilty, which though by no means tendered at the first opportunity, has spared the families the harrowing experience of sitting through a trial at which the distressing details would have had to be relived. I also recognise that you, like the families, have had to live with this matter hanging over you for approaching four years. I also take into account the fact that you recently instructed your legal advisers to make available to the court the expert report obtained on your behalf which as I have said, if anything made matters worse for you than did that for the HSE. You would have been quite entitled to withhold that report and I give you credit for that belated candour. Taking those three matters into account I reduce the starting point of six years by one third to an

effective sentence of four years' imprisonment concurrently on counts 1 and 2. This means that you will serve two years in prison without remission followed by a further period of two years on licence in the community under the supervision of the Probation Service. I wish to explain for the benefit of the families and public and, judged by previous ill-informed comments on other cases, especially for the benefit of certain members of the press and local politicians, that legislation obliges me to make the licence portion not less than one half of the overall sentence and it is for that reason that I do so.

[17] In relation to counts 3-21, the prosecution has accepted that, in the overall context of this case, they can be met by the imposition of fines. Accordingly, I impose a fine of £1,000 on each of those counts, a total of £19,000 which I will allow you 12 months to pay.

[18] I am also obliged by law to impose upon you a requirement to pay the appropriate offender levy.