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*(subject to editorial corrections)**

THE CROWN COURT IN NORTHERN IRELAND

SITTING AT ANTRIM

REGINA

-v-

COLERAINE BOROUGH COUNCIL

ICOS No: 13/50829

SENTENCING REMARKS

HIS HONOUR JUDGE MARRINAN

JUDGE MARRINAN: I am grateful to you all for your patience, this is a difficult matter to resolve but I have now come to a very clear view as to what should be done in this case.

The defendant Council has pleaded guilty to three counts under the Health and Safety at Work (Northern Ireland) Order 1978. Counts 1 and 2 relate to an incident that occurred on 22nd July 2011 at the defendant's civil amenity site at Loughanhill, Coleraine. Sadly as a result of the failures of the defendant Council, Mr Alan Devenney, then aged 39 and a longstanding and well liked Council

employee lost his life in tragic circumstances. Count 3 arises directly from an inspection of the Council's working practices particularly in relation to access to the public at the said site.

Counsel for the prosecution provided an extremely helpful written opening setting out the factual basis for the pleas in paragraphs 1 to 37 of her written opening and the defence take no issue with any of the key facts as recited in that document.

This accident occurred when the hook from a hook loader lorry failed to engage correctly with a fitting called a bale bar, on a container weighing together with its contents just over 11 tonnes. The hook instead caught on a steel cross-member which was not designed to take its weight or to support the weight. This permitted the lorry to lift the container but failed when the container came in contact with the rear rollers on the lorry causing the section to be damaged severely and the container to slide off suddenly, causing the fatal injuries to Mr Devenney.

The driver of the lorry was working without an assistant or a banks man and failed to notice that the hook had not engaged properly, nor did he notice the presence of Mr Devenney going about his work in close proximity to this operation. Part of Mr Devenney's job required him to pin and unpin these containers and also to sweep up waste which may have dropped from them, and doing this job conscientiously brought him into a blind spot in the position behind the container as far as the driver was concerned.

The relevant guidelines are referred to as CHEM standing for Container Handling Equipment Manufacturers Guidelines. These guidelines were drafted specifically to ensure there are no parts of the container which would connect inadvertently to the hook. A circular to that effect was issued UK wide by the Health and Safety Executive on 17th July 2008, some three full years before this accident. It provided very specific guidance on fitting a deflection plate to the bale

bar assembly which ensured that the hook could not engage or connect to any other part of the container except the bale bar. In giving that advice which was sent out on the web, those writing the advice said prophetically:

"*CHEM believes that accidents have occurred due to the non-engagement of the hook bar of the container with the hook of the hook lift equipment, and the hook is engaged instead with the underside of the cross-member sited above the hook bar. In these circumstances it is possible to raise the container off the ground until the tip of the hook will slide off the container and the container will fall*".

In this case the accident happened in a slightly different way but the guidelines were a very clear warning of the risk that actually occurred on this fateful day.

It is difficult, almost impossible, to know why this clear and relevant advice was not picked up by any of the responsible officers of the Council including the safety officer or the site manager or more senior management. I was told that such guidance is provided online UK wide. The simple precaution of checking such guidance periodically would have picked this up. If it had been picked up it certainly would have been acted on in my view. I am told that the provision of such a simple device was cheap and easy to construct and cost as little as £150. This was the first chance missed to protect Mr Devenney. In an age where such important information including safety guidance is provided online it would be desirable firstly, for the authorities to red flag such advice particularly if, as they suggest, that there was a previous history of accidents and equally it is inexplicable and unforgiveable that this clear guidance was not noticed, particularly as the Council had a dedicated safety officer whose sole responsibility was dealing with safety in relation to the sites operated by the Council.

Even more concerning however, was that a second chance to avert this tragedy was missed by the Council. They did have sight of relevant HSE guidance called "Skip and container safety and waste management and recycling" before the

incident. This guidance contains the following advice:

"*Larger containers...*" which would include this one "*...to have a deflector plate fitted at the top of the A frame to ensure that the vehicle hook engages correctly and safely with the container hook bale bar*".

This information and advice could not be clearer and was known. I have not been provided with any satisfactory explanation other than the obvious-- human frailty-- as to why this explicit advice was not taken up and followed.

To make matters worse, it is well recognised that hook lorries such as this with containers are very large plant and that blind spots exist for drivers attempting to manoeuvre these vehicles. Sadly, Mr Devenney was in such a blind spot doing his best in relation to his own job behind the container when he was struck. This task was not identified by the Council as requiring a reversing assistant.

Counts 2 and 3 deal with important but subsidiary issues to this tragedy, the risks to non-employees, including members of the public, who were not properly or safely controlled or marshalled and were able, until comparatively recently, to move freely around the site.

The Council also had arranged for risk assessments of its operations to be carried out in August 2009 and January 2011. Here was another opportunity missed to pick up on this very obvious risk. These risk assessments were conducted internally. They did not address the points made above or refer to any of the guidance which was in place and which would assuredly have prevented the tragedy occurring. It seems to me very clear that such risk assessments for an organisation of the size of the Council should be carried out by outside independent professionals who have great experience and understanding of the risks and may be expected to be fully conversant with the latest guidance and legislation. There may be a cost implication in this but this is completely irrelevant when it could and almost certainly would have led to robust advice

being given to the Council to install the relatively simple measures necessary.

Such advice was taken after the accident and it led to the Council taking various important steps including the fitting of deflector plates to all of their containers, the provision of larger signage warning the public and fitting rear facing cameras to the hook lorries to counteract the problem of the blind spots.

It is somewhat sad to reflect that the total cost of all of this was the very modest sum of £4,756. Further measures included the painting of the hook yellow to increase its visibility and instructions given to skip attendants such as the deceased, Mr Devenney. His remaining colleagues were instructed to remain at top of steps on an upper level until the loading and unloading operations were completed.

I am satisfied from everything that I have read and listened to that there were serious and culpable failings here. This risk had already been identified in guidance which should have been read and should have been acted on. The guidance specifically from 2008 recites that CHEM believed that accidents had already occurred due to the non-engagement of the hook bar of the container with the hook of the hook lift equipment. The Council is a major employer with a dedicated safety officer and appropriate senior staff and failed Mr Devenney in a way I find inexcusable, particularly as a significant portion of any Council's operations in Northern Ireland is to manage and recycle waste.

Management cannot escape its share of blame. They did not ensure that systems were in place and enforced to keep up with and implement vital safety guidance, guidance that was in place for several years before the accident.

The impact on the family of Mr Devenney has been devastating. He left behind a widow and two young children then aged 13 and 10. The victim impact reports make for grim reading. Out of respect for the family's wishes and their privacy, I will not dwell on the details of that suffice it to say that Mr Devenney clearly was a man who was dedicated to his family, a loving husband and father

with apparently a great sense of fun both at home and in the work place. All the plans and hopes for this young family were cut short in one dreadful moment. It is perhaps of some comfort to know that the family, including Mr Devenney's father-in-law, who also suffered considerably from the loss of his son-in-law, have faced this great loss with considerable courage, fortified by their strong faith.

Recently courts in Northern Ireland have followed the guidance produced by the Sentencing Guidelines Council in England and Wales in the absence of such guidelines being promulgated by the recently formed similar group in Northern Ireland. Clearly when dealing with serious breaches of health and safety legislation resulting in a fatality, it is important to look at those cases and those guidelines. I refer in particular to a number of cases which were shown to me such as the case of R v JNW Farm Ltd [2012] NICC page 17 and the case of R v Gallagher Ltd [2012] NICC 32. Both of those cases were decided by the then Recorder of Belfast. I found them extremely helpful and I seek to apply the guidelines which are referred to in those cases.

The sentencing guidelines in England and Wales contain the following propositions: In relation to seriousness it says:

"*Seriousness should ordinarily be assessed first by asking (A) how foreseeable was serious injury? The more foreseeable it was the graver usually will be the offence.*
(B) how far short of the applicable standard did the defendants fall? (C) how common is this kind of breach in this organisation? How widespread was the non-compliance, was it isolated in extent or indicative of the systemic departure from good practice across the defendant's operations. (D) how far up the organisation does the breach go? Usually the higher up the responsibility for the breach, the more serious the offence".

The guidelines continue: "*In addition, other factors are likely to aggravate the offence*". And they set out a number of conditions including, "*(A) more than one death or very grave personal injury in addition to one death. (B) a failure to heed warnings or advice whether from officials such as the Inspectorate or by employees especially health*

and safety representatives or other persons or to respond appropriately to near misses arising in similar circumstances. (C) cost-cutting at the expense of safety, (D) deliberate failure to obtain or comply with relevant licenses, at least where the process of licensing involves some degree of control, assessment or observation by independent authorities with a health and safety responsibility. (E) injury to vulnerable persons. In this context vulnerable persons would include those whose personal circumstances make them susceptible to exploitation".

Finally the guidelines then deal with the factors that may be relevant for purposes of mitigation:

"1) a prompt acceptance of responsibility.

2) a high level of cooperation with the investigation beyond that which will always be expected.

3) Genuine efforts to remedy the defect.

4) a good and healthy record

5) 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 guideline continues dealing with how the Court should approach the question of penalty. Mostly penalties will be financial penalties because one is dealing with an organisation rather than individuals. The guidelines continue as follows:

"The means of any defendant are relevant to a fine which is the principal available penalty for organisations. The Court should require information about the financial circumstances of the defendant before it. The best practice usually will be to call for the relevant information for the three year period including the year of the offence so as to avoid any risk of typical figures in a single year. It is just that the wealthy defendant should pay a larger fine than a poor one. Whilst a fine is intended to inflict a painful punishment it should be one which the defendant is capable of paying even if appropriate

over a period which may be up to a number of years".

Then in the final examples of guidance which I apply in this case the following factors are identified:

"*In assessing the financial consequences of a fine the Court should consider the following factors:*

1) the effect on the employment of the innocent may be relevant.

2) any effect on shareholders will, however, not normally be relevant. Those who invest in and finance a company take the risk that its management will result in financial loss.

3) the effect on directors will not, likewise, normally be relevant.

4) nor would it ordinarily be relevant that prices charged by the defendant might in consequence be raised, at least unless the defendant is a monopoly supplier of public services.

5) the effect upon the provisions of services to the public will be relevant; although a public organisation such as a local authority, hospital trust or police force must be treated the same as a commercial company where the standards of behaviour to be expected are concerned, and must suffer a punitive fine for breach of them, a different approach determining the level of fine may well be justified.

6) the liability to pay civil compensation ordinarily will not be relevant; normally this will be provided by insurance or the resources of the defendant will be large enough to meet it from its own resources.

7) the cost of meeting any remedial order will not normally be relevant, except to the overall financial position of the defendant; such an order requires no more than should already have been done.

8) whether the fine will have the effect of putting a defendant out of business this will be relevant; In some bad cases this may be an acceptable consequence".

Now applying all of that wise guidance I find as follows:

1), with regards the foreseeability of risk, in my view the risk of serious

injury including death was clearly and obviously foreseeable.

2) the Council fell far short of the standard expected of it particularly in such a potentially hazardous operation.

3) the operation continued for some three years in ignorance of clear and relevant guidance. There is however no evidence before me of any systemic departure from good practice through the Council's operations. I was told, for example, that no previous prosecutions had been taken against it nor were any warnings ever issued against it and that is a very relevant factor.

4) the managers of the Council are in my view fully responsible for the discharge of the duty of care to its employees.

In relation to any aggravating features I do not find any aggravating features in this case.

As regards mitigating features, I do find a number of those to be established:

1) a prompt acceptance of responsibility. It may be that the Council only recently pleaded guilty to these charges but it is quite clear to me from the earlier exchanges between health and safety officers and the police that they did accept their responsibility at an early stage. In this court as soon as the opportunity was offered to it to plead, it pleaded guilty.

2) A high level of cooperation with the investigation. I find that to be beyond that which was normally to be expected.

3) I find that there were genuine efforts to remedy the defect. Those efforts appear to have been entirely successful in addressing the risk.

4) a good health snd safety record, no previous prosecution or warnings.

Finally, a responsible attitude, although I qualify that by saying that I believe this can be improved with the assurance from the Council, which I hope will be forthcoming, that expert advice in risk assessment will be sought in future by commissioning such advice from outside the Council itself i.e. from

independent experts.

Now, it is of course trite to say that no penalty set by this Court can measure the life of a loved one. The penalty to be imposed weighs up all the factors both aggravating and mitigating to which I have referred. As in all criminal cases a prompt and unequivocal acceptance of responsibility is deserving of significant reduction in penalty, not least because such a public acceptance of guilt is a comfort to the grieving family who can be assured that they will not have to relive the tragedy in a contested criminal trial.

I also find evidence of real and considerable remorse in this case. This is a body of people, those who work for Coleraine Borough Council, who, if not a family, then certainly are people who work closely with each other and care for each other. The workforce from top to bottom has grieved for the loss of their friend and colleague, and have marked his passing with dignity and respect in ways shared appropriately with his family.

I have not been provided with detailed financial information about the Council although I understand from what counsel told me on instructions that substantial sums had been set aside to meet any likely fine. In the light of that I made no further inquiry into the Council's means.

In the sentencing guidelines in paragraph 19(5) it says,:

"*The effect upon the provision of services to the public is relevant, though a public organisation such as the local authority must be treated the same as a commercial company as regards the standards to be expected, a different approach to determining the level of fine may be justified*".

In the case of R v Milfordhaven Port Authority [2000] 2CAR page 423, Lord Bingham said at 433:

"*The judge has to consider how any financial penalty will be paid. If a very substantial penalty will inhibit the proper performance of a statutory body in relation to its public function that it has been set up to perform, that is not something to be disregarded*".

This is cited with approval in the guidelines. At paragraph 25, dealing with health and safety breaches from the less serious to the most serious cases, the guidelines say:

"*Where an offence is shown to have caused death the appropriate fine will seldom be less than £100,000 and may be measured in hundreds of thousands of pounds or more*".

As the Court of Appeal in England pointed out in R v Guys and St Thomas's Trust [2008] EWCA 2187, whilst the beneficiaries of the Trust's activities were the general public, and to impose a fine which reduced the ability of the Trust to serve the public was not in the public interest, that had to be set against the fact that a fine, a substantial fine, may serve the public interest "*...in causing those responsible for running the operation to redouble their efforts to ensure that their staff recognise the importance of being kept up to the mark as regards important safety concerns*".

In this case I found that the dangers were obvious. They had been indicated and identified specifically three years earlier and simple effective guidance had been given which was not followed up. This guidance, if followed, would have prevented this tragedy, I have no hesitation in saying that. I regard this case as one of serious failings and culpability.

I have looked at the cases referred to in the schedule provided and I have factored them into my thinking. On one analysis such failings suggest a penalty in the order of something like £150,000 should be imposed before discounting for a plea. However, bearing in mind in the current economic situation the difficulties faced by all councils in Northern Ireland and the well-publicised cuts to key public services anticipated and actual, I cannot see how such a level of penalty, even if discounted, would be of particular help to the public in any meaningful way and it might well make their lot harder.

Bearing all of those factors in mind and making all due allowances for the pleas of guilty in this case, I fine the defendant Council as follows: In respect of

Count 1, a fine of £50,000. In respect of Count 2, a fine of £12,500 and in respect of Count 3 a fine of £12,500, making a total of £ 75,000. In addition the defendant will pay the agreed costs which I believe I was told were £1,415.10.

MS IEVERS: If your Honour, I might intervene. I had asked for costs of £1,415.10, in fact your Honour, I am instructed to apply for £1,508.70.

JUDGE MARRINAN: Very well. All those costs and fines to be paid within four weeks from today.

(Case adjourned)