APPEAL COURT, HIGH COURT OF JUSTICIARY

[2023] HCJAC 30
HCA/2023/269/XC

Lord Matthews
Lord Boyd of Duncansby
Lady Wise

OPINION OF THE COURT

delivered by LADY WISE

in

Crown Appeal against Sentence

by

HIS MAJESTY'S ADVOCATE

Appellant

against

TIGH-NA-MUIRN LTD

Respondent

Appellant: Cameron, AD; Crown Agent
Respondent: B Smith KC; Faculty Services Limited

18 August 2023

Introduction

[1] On 2 May 2023 the respondent company pled guilty to an indictment served under section 76 of the 1995 Act libelling a charge in the following terms:

> "between 20 March 2020 and 1 June 2020, both dates inclusive, at Tigh-Na-Muirn Residential Home at 4 Victoria Street, Monifieth, Dundee, DD5 4HL you TIGH-NA-MUIRN LTD being an employer within the meaning of the aftermentioned Act, did fail to conduct your undertaking in such a way as to ensure,

so far as was reasonably practicable, that persons not in your employment, namely residents of said Tigh-Na-Muirn Residential Home, in particular David Fyfe, now deceased, who may have been affected thereby, were not exposed to risks to their health and safety in that you did:

(a) fail to make suitable and sufficient assessment of the risks associated with the storage of cleaning products within resident's rooms; and

(b) fail to ensure that the exposure of your residents to hazardous cleaning chemicals was prevented or, where this was not reasonably practicable, adequately controlled;

and in consequence thereof, on 6 May 2020 a bottle of ammonium - based cleaning liquid was placed beside toiletries on top of a cabinet above the sink in the bathroom of said David Fyfe and on 27 May 2020 David Fyfe ingested a quantity of the liquid and in consequence he developed acute severe inflammation in his airway and pneumonia from which he died on 31 May 2020: CONTRARY to section 3(1) and 33(1)(a) of the Health and Safety at Work etc Act 1974."

[2] At an adjourned diet on 10 May 2023 the sheriff imposed a financial penalty of £30,000, which she discounted by one third to £20,000 in light of the company's guilty plea at the first opportunity. A victim surcharge of £1,500 was payable. The Crown appeals against the level of fine as unduly lenient.

The facts

[3] Tigh-Na-Muirn Ltd (TNM) operates a privately owned residential care home, registered for a maximum of 59 service users. The company has two directors, a married couple, although only the husband is involved actively in the business. The company has no previous convictions.

[4] David Fyfe was admitted to TNM residential home on 24 November 2019 for emergency respite. He was 90 years old and suffered from various underlying health conditions, including Alzheimer's disease. From January 2020 his wife consented to him residing at the home permanently. His room was located in the garden wing of the

property. A care plan for Mr Fyfe indicated that he walked with the assistance of a walking frame/walking stick. He became easily distracted, was at low risk of falls and of leaving the home unnoticed. He had no difficulties eating, drinking, swallowing or chewing. The care plan indicated that due to his dementia he was unable to administer his own medication and this was managed by staff daily.

[5] By February 2020 the coronavirus pandemic was creating a public health emergency. COVID-19 care procedures for TNM were outlined in the COVID-19 resilience plan made in February 2020 by a full team of 18 managers. The resilience plan was updated regularly, following advice from HSE, Public Health Scotland, Health Protection Scotland, Care Inspectorate, Social Work and Angus Council. TNM staff found that advice was changing daily and official information was sometimes confusing or conflicting. TNM employ health and safety consultants whose remit at the relevant time was to be advisors. They were not approached by TNM in relation to the resilience plan, which was based on the availability of supplies at any given time. In terms of cleaning materials to be used for Covid positive residents' rooms, clinical wipes would have been the staff's preferred option but supply issues associated with the pandemic made this unfeasible. The resilience plan was accordingly altered to include Sterigerm cleaning sanitiser. The plan stipulated that isolated rooms would have their own cleaning kits, which would be kept in each room and not removed. Sterigerm was stored for use in a screw top spray dispenser. The decision to use Sterigerm and store it within Covid positive residents' rooms was taken by those operating the care home as a team.

[6] The COVID-19 resilience plan was used in tandem with resident specific Covid care plans. Mr Fyfe had presented with a cough on 6 May 2020 and thereafter returned a positive COVID-19 test result. He was placed in temporary isolation within his room to prevent the

spread of COVID-19 amongst residents and staff in accordance with the protocols in place at the time. The final day of his isolation was to be 27 May 2020. According to the mental health manager, during his isolation period Mr Fyfe was more confused than normal and she had contact with him daily to help him understand what was going on. She assisted with his personal care, laundry and room cleaning. She last cleaned his room on the morning of 26 May. She stored the cleaning products towards the back of the top of the bathroom cabinet as per the instruction.

[7] On 27 May 2020 a carer checked on Mr Fyfe at around 7.40am. He appeared content, and asked when breakfast would be served. The carer advised him that it would not be long and did not enter the room. The carer did not see any cleaning chemical visible in the room. At around 8.30am, Mr Fyfe came to his door and was observed by a staff member to be sweating profusely, having breathing difficulties, and speaking with a hoarse voice. He was clutching his chest and stated that he had chest pain. A registered nurse on shift was immediately notified. His blood oxygen saturation level was 94 and an ambulance was requested using the 999 system.

[8] Mr Fyfe was moved to the open patio door to assist him with his breathing. Staff then observed a plate of food, a china cup and a paper cup with green residue on the table next to an unlabelled screw top spray bottle of cleaning sanitiser, still with the lid on. The paper cup had a green residue in the bottom which was the same colour as the cleaning sanitiser. Mr Fyfe was unable to clarify whether he had consumed any of the liquid. By the time paramedics arrived about 15 minutes after they were called, Mr Fyfe's blood oxygen saturation had dropped to 88 and he had fluctuating chest pain and breathing difficulties. He was admitted to Ninewells Hospital and gradually deteriorated over the following few

days. Clinical staff ultimately determined that he be given palliative treatment and he died on 31 May 2020 at midnight.

[9] A post-mortem examination revealed the primary cause of death to be acute tracheobronchitis and pneumonia, resulting from the ingestion of ammonium based cleaning product. Ischemic heart disease and Alzheimer's disease were regarded as contributory factors, due to the detrimental impact that these both would have had on Mr Fyfe's physiological resilience and ability to tolerate injury to the respiratory system and metabolic insult.

[10] A subsequent local authority investigation found that control of substances hazardous to health (COSHH) risk assessments had been carried out but had not covered risk to residents from chemicals as these were not usually left in a way exposed to residents. Cleaning chemicals were never usually kept in residents' rooms and were stored in a locked cleaning cupboard. Due to the circumstances of the pandemic and in the interest of infection control, staff had been instructed that cleaning products issued to Covid positive rooms, including Mr Fyfe's, were to be stored on the *en suite* bathroom cabinet. Company procedure for each bottle was to have labels on both sides including instructions for use and it was not known why the bottle of Sterigerm in Mr Fyfe's room had no label.

[11] TNM's health and safety policy includes a chapter on risk assessment procedure. This laid down a five step process for any risk assessment to include the following stages:

1. Identify the hazards.
2. Identify who may be harmed and how.
3. Evaluate and control the risk.
4. Record the findings.
5. Monitor and review the assessment.

Mr Fyfe had his personalised "My COVID-19 infection control plan" which was classed as a risk assessment. It did not consider any hazards to him by storing chemicals in his room, thus omitting step one in the usual risk assessment process. Accordingly there had been a failure to conduct an adequate risk assessment.

[12] Following Mr Fyfe's death, the company provided locked boxes in which cleaning materials such as Sterigerm could be stored. These were named "Covid response boxes" and were kept locked outside resident's rooms. The home also now has access to wipes so that the use of Sterigerm is no longer required. The locked boxes were in place by 7 July 2020.

The sheriff's report on sentence

[13] The sheriff states in her report that she began by considering the seriousness of the offence in terms of harm and culpability. Applying the first of the principles set out in *Scottish Sea Farms Ltd* v *HM Advocate* 2012 SLT 299 at paragraphs 18-19 she considered that given that death resulted from the incident, the harm was extremely high and could only have been greater had multiple deaths occurred. The sheriff then considered if any aggravating factors applied. The company's submission that this was not a breach with a view to profit was accepted. No financial gain was made, nor intended to be made. The breach was not deliberate but occurred by omission. However, the sheriff considered that an aggravating factor was that Mr Fyfe was a vulnerable individual as a result of his Alzheimer's disease and the company were entrusted with his care.

[14] In considering the degree of risk and extent of danger in terms of culpability, the sheriff concluded that culpability was low for the following reasons:

- The management team did not have any cause to imagine that Mr Fyfe might deliberately or accidentally ingest the cleaning agent;

- Genuine efforts were being made in extremely challenges circumstances to respond to and react to a rapidly changing situation and to keep residents and staff safe, although they were inadequate on this occasion; and
- The incident was an isolated one.

[15] So far as mitigation was concerned the sheriff recorded that a guilty plea had been tendered at the earliest opportunity avoiding the need for a trial. The company had taken effective steps to remedy the deficiency and the local authority documents indicated efforts had been made by all concerned to comply with health and safety duties. It was accepted that the company had a responsible attitude to health and safety and an excellent safety record. Finally, regard was had to the resources of the company and the effect of a fine on its business. The accounts indicated that turnover was consistent at around £3 million per year. Net profit was over £400,000 in 2018 but had reduced to around £366,000 in 2021. It was noted also that the company currently faced financial challenges caused by significantly increasing energy costs, food costs, staffing costs and post Covid infection control measures.

[16] Having regard to the Scottish Sentencing Council's principles and purposes on sentencing guideline requiring a sentence to be imposed which was no more severe than was necessary, the sheriff ultimately came to the view that a fine at the lower end of the range of possible sentences was appropriate. The Definitive Sentencing Guideline on health and safety offences issued by the Sentencing Council for England and Wales was used as a crosscheck and again the conclusion was reached that culpability was low. The harm fell into Level A in terms of seriousness with a medium likelihood of harm (Harm Category 2) but given that other residents had also been at risk the harm felt to be assessed towards the upper end of Category 2. This was a small company and in a category in which the English Guideline would indicate a fine ranging from £3,000-£40,000 for Category 2 offences with a

starting point of £9,000. On that basis the sheriff considered that a starting point of £30,000 fell within the upper end of Category 2 offences.

Submissions for the appellant

[17] On behalf of the Crown it was accepted that for the appeal to succeed it must be shown that the sentence imposed fell out with the range of sentences which a sheriff at first instance, applying her mind to all the relevant factors, could reasonably have considered appropriate – *HM Advocate* v *Bell* 1995 SCCR 244 at 250D. It was submitted that the sheriff had erred in her assessment of the respondent's culpability and in categorising it as low. There had been a failure to give due weight to the seriousness of the offence and the exposure of risk presented to the residents of the care home and in particular to a vulnerable, confused and isolated resident such as Mr Fyfe. The exposure to risk arose directly because the respondent failed to make any risk assessment and to prevent or adequately control exposure to hazardous chemicals. Those failings had caused Mr Fyfe's death. The fact that genuine efforts had been made to keep residents and staff safe during the pandemic could not be regarded as a factor relevant to the degree of risk and to the extent of danger. The sheriff had conflated the risks presented by COVID-19 with the failures to which the respondent had pled guilty.

[18] Further, the sheriff had specifically categorised this as an isolated incident when both the libel and the narrative illustrated that the failures had continued over a period of 2 months. It was clear from the *Scottish Sea Farms* case that a failure or failures continuing over a period were to be contrasted with an isolated incident. A submission was also advanced initially that there was no proper basis for the sheriff's view that the company had "no cause to imagine" that Mr Fyfe would ingest the cleaning fluid. This was later

withdrawn as the procurator fiscal depute who appeared at the sentencing diet had apparently not taken issue with that contention being made on behalf of the company.

[19] Further, it was contended that the sheriff's approach had been to minimise the existence of aggravating factors and emphasise the mitigatory factors. She relied on the absence of failure to put in place industry standards, the fact that the company had not allowed breaches to subsist over a long period of time, that there were no serious or systemic failures within the organisation to address health and safety and that significant efforts had been made to address the risk although they were inadequate. The sheriff accordingly misdirected herself in relying on those factors as they were inconsistent with the charge to which the company had tendered a plea of guilty and inconsistent with the narrative presented to the court. The advocate depute submitted that the correct category of culpability in the circumstances of the case was in the range of medium to high. The company had been responsible for a clear failure to put in place industry standards in relation to the control of substances hazardous to health for the period of the libel (20 March 2020 - 1 June 2020). Such a failure could be said to constitute a serious or systemic failure to address health and safety. The absence of a relevant risk assessment meant the company fell short of the appropriate standard and they had failed to ensure that vulnerable residents such as Mr Fyfe were not exposed to hazardous chemicals. The sheriff had also erred in her approach to the issue of harm as set down in the English Definitive Guideline. Assessing harm required consideration of both the seriousness of harm risked and the likelihood of harm arising. Once those were identified consideration had to be given to whether the offence exposed a number of workers or members of the public to the risk of harm and whether the cause of the offence was a significant cause of actual harm. In the present case

the company had occupied a position of trust and responsibility to vulnerable residents. Their breach of statutory duty risked a high level of harm and the likelihood was also high.

[20] In relation to the appropriate level of fine the policy underpinning the health and safety at work legislation had to be borne in mind as should the requirement to punish companies for such breaches – *HM Advocate* v *Munro & Sons* 2009 SLT 223 at paragraph 34. In selecting a headline sentence of £30,000 the sheriff had chosen an unduly lenient penalty. It was far too low and failed adequately to reflect the seriousness of the offence to which the respondent had pled guilty. There was no indication in the sheriff's report as to how she had arrived at the figure of £30,000 or how it met the sentencing aims. The level of fine required to be meaningful and send a message to those with health and safety duties. It was accepted that the sheriff had to ensure that the effect on the company would not be catastrophic but that had to be balanced against the need for it to be meaningful - *Scottish Power Generation Ltd* v *HM Advocate* 2017 JC 85 at paragraph 44. In that case, the court had indicated support for using the English Guideline as a crosscheck. However in the present case even using the guidelines, the sheriff had arrived at an unduly lenient level of fine because of her failure to assess culpability correctly by giving insufficient weight to the nature and extent of the breach and by giving too much credit to mitigatory factors. In essence the company did not have a system for storing this particular hazardous substance that had been risk assessed and was appropriate. The failings were neither minor nor isolated.

[21] It was submitted that as the risk continued for over a period of 2 months and was posed to nearly every resident in the home the harm category should have been assessed as 1 and not 2. The sheriff had failed to move up a harm category despite the existence of both of the factors justifying her doing so. It was consistent with both Scottish authorities

and the English guidelines that the consequences of the breach had to be taken into account. The final stage of the exercise had to be to step back, renew and adjust the sentence to fulfil the objectives of sentencing. Had the correct approach been taken the figure would have been a very substantially in excessive of that selected.

Submissions for the respondent

[22] Senior counsel for the respondent, who had appeared at the sentencing diet before the sheriff, emphasised that he had tendered detailed written submissions in advance of the diet and that the sheriff had taken time to consider those and reach her decision.

[23] It was submitted before the sheriff and reiterated by senior counsel in responding to the appeal that the circumstances of Mr Fyfe's death took place against the backdrop of the COVID-19 pandemic. That was relevant context for the sheriff to consider. The advice to care home businesses such as the respondent was changing daily. In storing a cleaning agent in Mr Fyfe's *en-suite* the respondent was following advice that items should not be taken in and out of rooms and should be either single use or stored in a room if a resident was isolating. It was not known why the bottle containing the Sterigerm was unlabelled but it was known that the practice was to transfer the cleaning agent into bottles from a large storage container. There was a trigger mechanism on top of the bottle. Advice was being given to the care home sector effectively by government filtered through the local NHS Trust.

[24] The staff in the care home were following published advice at all times. The officially mandated protocol required infected residents to be isolated in their own rooms and staff entering their rooms to assist with care were required to wear full PPE and adhere to a strict hygiene regime. Sanitising kits were provided for each infected resident's room

and retained within them. The practice in relation to cleaning products required by the COVID-19 guidance represented a deliberate change from the normal procedure in place at the home. Before the pandemic cleaning products had been retained in a locked cupboard by domestic staff and taken on trollies for use whilst cleaning and then returned to the locked cupboard. That process had been the subject of a full COSHH risk assessment. The company now accepted that the Sterigerm ought not to have been stored in an accessible place in Mr Fyfe's room but his personal assessment had not indicated that he might deliberately or accidentally ingest the cleaning agent.

[25] The company had pled to a failure to make an adequate risk assessment rather than no risk assessment at all. However, given that there were more than five employees the council acknowledged that the relevant regulations required a suitable and sufficient risk assessment to be reduced to writing and that had not been done in relation to the Covid resilience plan. Accordingly, there had been no risk assessment in writing of the new hazard presented by storing an ammonium based cleaning agent in residents' rooms. The point was that the failure could not be separated from the Covid circumstances and the necessity to isolate those with positive COVID-19 test results.

[26] Senior counsel conceded that the plan which had turned out to be inadequate had been in place throughout the two and a half month period of the libel. However there had been a number of mitigatory factors including that the company had responded appropriately, promptly and responsibly to Mr Fyfe's ingestion of the Sterigerm and consequential death. The new plan of the locked boxes had been devised and the company had cooperated fully in the health and safety executive investigation. Both prior and subsequent to the relevant period the company had taken the health and safety of its

employees and residents very seriously and had expressed sincere regret for the breach and its tragic consequences.

[27] Where the English guidelines were relevant as a crosscheck, both the harm category and the culpability category required to be utilised. Counsel maintained that the culpability in this case remained low.

Decision

[28] The court is grateful for, and has given careful consideration to, the helpful submissions on behalf of both the appellant and respondent in this sad case. There is no dispute as to the applicable law. The relevant principles were summarised in *Scottish Sea Farms Ltd* v *HM Advocate* 2012 SLT 299 at paragraph 18 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; and

(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.

As this approach is reflected in the English Guideline, it should be used as a cross check on Scottish precedent, though not applied mechanistically (*Scottish Power Generation Ltd* 2017 JC 85, at paragraphs 35-37).

[29] In this case, the focus is on the sheriff's assessment of culpability and whether she failed to reflect the degree of risk and extent of danger, with particular reference to whether this was an isolated incident or continued over a period. The sheriff seems to have overlooked, or at least not placed any emphasis on, the period of the libel. For two and a half months the company breached a standard that they had hitherto adhered to, namely of ensuring that residents were protected from any risk of ingesting hazardous substances by keeping these in a locked cupboard. Accordingly, the sheriff was wrong to categorise the incident as an isolated one as there was a continuing breach. The simple and effective procedure of keeping locked boxes outside the room of any resident who was isolating following Mr Fyfe's death illustrates that had the proposal to store the substances in a resident's *en-suite* bathroom been risk assessed in any meaningful way, a different result would have ensued.

[30] The direction given to the care home required them to consider how best to isolate a COVID-19 positive resident while minimising any other risks to health and life. They failed to make any appropriate assessment for the whole period. The sheriff's assessment failed to take sufficient account of the fact that the failure led directly to Mr Fyfe's death. Further as he was a vulnerable person with reduced cognitive function with far less staff contact because of the requirement to isolate, there was a heightened responsibility to assess any risk arising from his isolation and changed hygiene practices. All of these factors ought to have been taken into account.

[31] So far as the context is concerned, the respondent company, like so many care home businesses, was faced with extraordinary circumstances in the first months of the COVID-19 pandemic. The unprecedented circumstances in which care homes were operating and the genuine efforts TNM were making generally to keep their residents safe was mitigatory, but the sheriff placed undue emphasis on it in assessing culpability, commenting that they had fallen short "on this occasion". The repeated references to this being a single breach are indicative of a flawed approach to culpability assessment. Accordingly, we disagree that culpability in this case could properly be assessed as low. The sheriff gave inadequate consideration to the degree of risk and the extent of the danger, and failed to recognise that the breach was not an isolated incident but continued over a period of time; *Scottish Sea Farms Ltd*, paragraph 18(c).

[32] This flawed approach has led to the imposition of an unduly lenient sentence. Accordingly, we must consider an appropriate level of fine of new.

[33] Having regard both to the applicable principles and the English Guideline, we assess culpability in this case as at least medium. The ongoing failure to assess the obvious risk of changing a system of locking away a hazardous substance and placing it within reach of residents was serious. Indisputably significant harm was caused in this case as death occurred. So far as assessing the risk of harm is concerned, while the sheriff may have been correct to regard this as no higher than Category 2, it can be seen as rather at the higher end of that category. It is agreed that the respondent should be categorised as a small company. Had the sheriff not erred in her assessment of culpability, and using the English Guideline as a crosscheck, the starting point for a financial penalty in this case would have been either £54,000 with the range being from £25,000-£230,000 (for Medium Culpability and

Harm Category 2) or £100,000 with a range of £50,000-£450,000 (for High Culpability and Harm Category 2).

[34] We consider that the level of fine might have been at the higher end of the Medium Culpability and Harm Category 2 range but for the mitigating factors on which the sheriff quite properly relied. The offence occurred in a care home when the COVID-19 pandemic was at its full height and when care homes in particular were operating under enormous pressure. We also recognise that the offence occurred as a result of staff attempting to ensure that residents were kept safe by minimising items coming in and out of resident's rooms and possibly spreading infection. Nevertheless, we consider that the fine imposed by the sheriff failed to fulfil sufficiently the relevant sentencing objective of punishment and deterrence. We acknowledge that sufficient account should be taken of the company's financial position in assessing the correct level of fine. However, the information provided in relation to turnover and profitability does not cause us concern that the ongoing business of the care home will be threatened by the fine we intend to impose.

[35] For these reasons, we shall allow the appeal, quash the sentence and substitute a fine of £60,000, reduced from a starting point of £90,000 in light of the early plea.