APPEAL COURT, HIGH COURT OF JUSTICIARY

[2023] HCJAC 17
HCA/2023/000070/XC

Lord Pentland
Lady Wise

OPINION OF THE COURT

delivered by LORD PENTLAND

in

Appeal against Sentence

by

ST DAVID'S CARE FORFAR LIMITED

Appellant

against

HIS MAJESTY'S ADVOCATE

Respondent

Appellant: Culross; Jackson Boyd Lawyers
Respondent: Trainer, advocate depute ad hoc; Crown Agent

23 May 2023

Introduction

[1] On 10 February 2023 at Dundee Sheriff Court the appellant company pled guilty to an indictment served under section 76 of the 1995 Act libelling a charge in the following terms:

> "On 12 January 2017 at St. David's Care Home, 38 Glamis Road, Forfar … you … 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 who may have been affected thereby were not exposed to risks to their health or safety in that you did fail to provide effective arrangements to prevent residents from leaving the care home unnoticed without alerting your staff to their movements in that you de-activated an alarm on the fire door in the dining room which enabled resident Georgina Norrie to leave the building in the early hours of the morning unnoticed, whereby she was locked out and consequently she suffered from hypothermia which caused the death of the said Georgina Norrie; CONTRARY to Section 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974."

[2] The sheriff imposed a fine of £100,000 discounted for the plea from £150,000. The fine was to be payable at the rate of £1,500 per month. He also imposed a victim surcharge of £7,500.

The facts

[3] The appellant operated St David's as a privately owned care home for a maximum of 22 older people. Residents had their own rooms. The directors of the company are a married couple, both formerly registered nurses. A care inspectorate report dated 14 November 2016 graded the home's quality of care, support and staffing as excellent and suggested no improvements. No complaints had been upheld against the appellant in the preceding year. Historically it had achieved high scores and grades when inspected.

[4] The deceased was an elderly, frail lady who suffered from learning difficulties, advanced dementia, diabetes and chronic renal disease. Due to her dementia she had no understanding of her condition and wholly lacked capacity. By January 2017 the deceased had become more confused about where her room was and generally in and around the home. She tended to get up several times each night looking for food. She had lost weight, was unsteady on her feet and had suffered falls. She needed assistance to visit the toilet.

[5] At the time of the deceased's death there was no CCTV system in the home. Each bedroom was, however, fitted with a motion sensor which, when triggered, alerted staff to movement in the room.

[6] The deceased's individual risk assessment stipulated that her room motion sensor should be switched on to alert carers to her movements during the night. Although the sensor sometimes activated when the deceased moved in bed, it began to do so less frequently around 6 months before her death and often did not activate at all when she got up and left her room.

[7] At some point a piece of tape had been applied over the sensor. Neither of the carers on duty on the night of the deceased's death was aware that this had occurred.

[8] At the time of the deceased's death all but one of the entrances and exits to the home were locked and/or alarmed. The exception was a fire door leading to a patio and a garden from the dining room. This door could only be opened internally.

[9] The appellant took steps to prevent residents leaving the home at night. A wall bordered the front of the property, the front gates were secured by chains and a padlock and the rear main gate was locked and secured by means of a keypad.

[10] On the night of 11 January 2017 the two duty care assistants were instructed to check on all residents at 2200, 0200 and 0600. Each check included ensuring that residents were in bed and that motion sensor alarms were switched on. Both care assistants were aware of the deceased's state of health.

[11] The check conducted at 0200 disclosed that the deceased was in bed and that her motion sensor alarm was switched on. However, a further check at 0610 revealed that she was not in her room. As her motion sensor had not activated, neither staff member had been alerted beforehand.

[12] Both carers searched the home but were unable to find the deceased. One carer then left the home through the dining room door, which was not alarmed. She found the deceased in her nightwear outside, lying on her back at the door facing Glamis Road. Although the deceased was conscious and breathing, she appeared very cold and was using her hands to rub her upper arms in an attempt to warm herself.

[13] The carers carried the deceased, who remained conscious, back to her bed. An ambulance was called, her wet clothing removed, and attempts made to warm her up. Notwithstanding these efforts, the deceased's breathing changed, her eyes became glazed and she ceased breathing. CPR was commenced until the carers became aware that the deceased's care plan confirmed that a Do Not Attempt CPR certificate was in place. At 0714 a paramedic attended and pronounced life extinct.

[14] An autopsy on 16 January 2017 identified the deceased's cause of death as 1a) atherosclerotic coronary artery disease and hypothermia (outdoors).

[15] Subsequent investigation disclosed that the home's general risk assessment for all residents should have identified a need for every exit door to be alarmed, particularly at night and in colder weather, in order to alert the staff to any movements of residents and to reduce the risk of anyone leaving the building unnoticed. While the risk assessment stated that suitable security measures should be provided to prevent unauthorised access to the premises and residents leaving them unnoticed, such measures required to be proportionate and to balance the appellant's duty of care against residents' rights to exercise independence.

[16] Health and safety officers from Angus Council subsequently found:

a) A suitable and sufficient risk assessment would have identified that exiting the building unnoticed was a hazard which posed significant risks to residents,

including falls potentially leading to injury or death, exposure to cold temperatures potentially leading to hypothermia or death and emotional distress if residents were unable to gain entry;

b) such risks were exacerbated during the night and in winter as they were unlikely to be noticed and would expose residents to cold temperatures;

c) other residents had exited the home through the fire door and had been found outside;

d) as the dining room fire door was used during day time hours and as the deceased was known to frequent the dining room during the night, there was a risk that she might use the fire door during the night; it was foreseeable that a resident might use the door during the night to leave the building;

e) a suitable and sufficient risk assessment would have identified suitable controls to prevent a resident such as the deceased exiting the home during the night; and

f) any such suitable controls, for example a functioning alarm, would have alerted staff to a resident having exited the building during the night. The fitting of such an alarm was a reasonably practicable preventative measure for the appellant to have implemented.

The sheriff's approach to sentence

[17] It is clear from his detailed and careful report to this court that the sheriff gave close consideration to all the circumstances of the case in determining the appropriate penalty to impose. He took the view that the offence was aggravated by several factors, most seriously by its having caused the deceased's death. In addition, other aggravations were evident from the agreed narrative.

[18] First, the incident related to a person suffering from dementia and occurred in premises where the appellant provided specialised care to vulnerable persons. As such, the appellant occupied and breached a position of trust and responsibility.

[19] Second, the appellant knew that the deceased exhibited symptoms and behavioural patterns which were likely to expose her to danger. She had advanced dementia, had no understanding of her condition and wholly lacked capacity; her other difficulties created separate foreseeable risks - she had learning difficulties; she was unsteady on her feet, was susceptible to falls, was confused, had a habit of getting out of bed several times each night to look for food and was known to frequent the dining room when she did so.

[20] Third, although the appellant's personal risk assessment for the deceased specifically recognised those dangers and contained measures designed to address or minimise the risk created by them, the appellant took steps which deliberately circumvented them. In particular, the assessment recognised the risk created by the deceased leaving her room at night and addressed it in part by providing for a motion sensor alarm to be fitted in her bedroom; this would alert staff to her movements. However, by placing tape over the sensor, and by failing to take steps to consider the sensor when it failed to operate in the 6 months preceding the deceased's death, the appellant culpably failed to consider the danger the tape created, ignored the risk assessment, took no steps to inspect the sensor, install a different sensor or consider and provide a suitable alternative. Thereby, the appellant knowingly allowed a control mechanism, which was crucial to the deceased's safety, to disappear. That the sensors in the building were old, were not installed by the appellant, were faulty and no doubt inconvenienced the deceased and other residents at night, were all, in context, irrelevant factors.

[21] Fourth, the appellant ignored two further factors - the deceased was known to frequent the dining room area at night and, separately, other residents had exited the home through the fire door and had been found outside. The appellant did not address the obvious risk created at night by the absence of an alarm on the dining room fire door. Again, that failure ignored a risk assessment which noted that steps required to be taken to prevent vulnerable service users such as the deceased leaving the premises unnoticed.

[22] The sheriff also recognised the existence of mitigating factors and the absence of other recognised aggravating features - the appellant promptly reported the incident and fully co-operated with subsequent investigations. There was a reasonably prompt acceptance of liability after disclosure of the evidence. The appellant had an otherwise unblemished health and safety record. It had been consistently rated highly in regulatory reports. It had an excellent reputation. It took steps to address its failures. Its directors and staff appeared to have been genuinely devastated by the circumstances of the deceased's death. It was not suggested that the breaches occurred with a view to profit. It was not suggested that this was anything other than an isolated incident or that the appellant failed to heed advice. One of the directors had recently suffered a life-changing diagnosis which it was well-known could be brought on by stressful events. Finally, there had been no further incidents since the deceased died.

Amount of the fine

[23] Before the hearing the sheriff had been provided with copies of the appellant's "financial statements" for its financial years ending in March 2020 and 2021. Those statements transpired to be the abbreviated balance sheets which the appellant had lodged

with Companies House as a small company exempt from lodging full accounts in terms of section 477 of the Companies Act 2006.

[24] The sheriff observed that unfortunately he had not been provided with detailed information which might have been useful, in particular details of the appellant's profit margins, its cash flow, its profit and loss accounts or any other accounts prepared for 2022. The sheriff noted that, as the appeal court observed in *HMA* v *Munro & Sons Highland Limited* 2009 SLT 233 para [30], in a case such as this the company should provide the court with detailed information to enable the court to see its complete financial picture without resorting to speculation.

[25] From the information given in the financial statements the sheriff noted that the appellant held assets valued between £1.75 to £1.9 million and, net of its liabilities, had net assets valued in excess of £600,000. It was not submitted on behalf of the appellant that it would be unable to pay a fine. There was no suggestion that the appellant's operations were unprofitable.

[26] While the sheriff accepted from the information put before him that the appellant's energy costs had increased, he considered that these were capable of being recovered from private paying residents and he noted that the appellant's cash flow was reasonably consistent.

[27] The sheriff observed that while the financial statements disclosed that the appellant's current liabilities included a bank overdraft of nearly £400,000, almost all the remainder comprised directors' loans. It was not suggested to the sheriff that the appellant was unable to service its overdraft, no longer enjoyed the continued support of its bankers and/or that there was any likelihood that the directors' loans would be called up. In those circumstances the sheriff inferred that the appellant had no immediate financial difficulties

and, even under deduction of its current liabilities, it still held net assets valued in excess of £600,000.

[28] The information available to the sheriff strongly suggested to him that a substantial fine would not adversely affect the appellant's solvency, the continued employment of its staff or its ability to care for residents. Finally, as the deceased had died 6 years earlier and it had been known at an early stage that a prosecution was almost inevitable, the appellant had had adequate opportunity to make advance financial provision to meet a fine.

[29] The sheriff took the view that the fine had to reflect the public interest by punishing the appellant for failing to pay due regard to the deceased's safety. He viewed the failure in this case as highly significant because it occurred in an environment designed to protect vulnerable persons, as it had resulted in the deceased's death and was aggravated by other important factors. No one other than the appellant was responsible for the failure. For those reasons, the sheriff considered that a substantial and meaningful fine was justified.

[30] From the information which the appellant chose to submit to the court, the sheriff assessed that, at highest, the appellant could theoretically realise or borrow against the value of its average net assets, in other words around £600,000. He appreciated, however, that many of those assets could and should not be realised as they were needed operationally and that it was inherently likely that the appellant could borrow that amount or service that level of debt.

[31] Consequently, using the net asset figure as a base reference and applying a broad brush, the sheriff assessed that the appellant was able, at highest, to meet a fine of half the value of its net assets in other words, around £300,000.

[32] However, that figure ignored two other classes of relevant factors. The first was that the interests of the appellant's residents and staff needed to be protected and any possibility

of insolvency should be avoided. The second was the mitigating factors and the absence of the other recognised aggravating factors. Again, applying a broad brush, the sheriff regarded each class as a substantial factor, each of which justified a further 25% reduction.

[33] Consequently, the sheriff assessed that a proportionate and reasonable headline fine would be £150,000 which, after applying a discount in terms of section 196 of the 1995 Act, he restricted to £100,000.

Submissions for the appellant

[34] On behalf of the appellant it was submitted that the sheriff's approach was inappropriate and that he had given insufficient weight to the mitigatory factors.

[35] The sheriff had erred by not applying the Definitive Sentencing Guideline issued by the Sentencing Council for England and Wales on *Health and Safety Offences, Corporate Manslaughter and Food Hygiene Offences*. Its use had been approved in Scottish case law (*Scottish Sea Farms Ltd* v *HM Advocate* 2012 SLT 299 at para [25]). The sheriff had failed to consider the culpability of the company before addressing the likelihood and seriousness of the incident; and thereafter the resources of the company. It was accepted that the sheriff had not been referred to the Guideline at the sentencing diet, but it was nonetheless submitted that it could be relied on to support an appeal on the basis that the fine imposed was out of line with what would be considered appropriate in terms of the Guideline.

[36] Given the small size of the company and its limited turnover, the level of fine imposed indicated that the sentence was commensurate with very high or high culpability under the Guideline. This assessment was unfounded. The appellant had not fallen far short of the appropriate standard, for example by failing to put in place measures recognised as standards in the industry, or by ignoring concerns raised by employees or

others, or by failing to make appropriate changes following prior incidents exposing risks to health and safety, or by allowing breaches to subsist over a long period of time. For an assessment of very high culpability the sheriff would have had to find that there was a deliberate breach or a flagrant disregard for the law. None of these elements formed part of the circumstances of the case; high or very high levels of culpability were not justified. The sheriff erred in the classification of culpability.

[37] It was acknowledged that since a death had occurred the seriousness of the harm was at Level A (page 5 of the Guideline). Thereafter the correct approach was to consider the wider risk to the public, and other people (staff and residents); and whether the offence was a significant cause of the actual harm.

[38] Step two in the Guideline required an assessment of the company's finances and of the aggravations and mitigations. The appellant was a very small (micro) company with limited resources. Had that been properly assessed, the starting point for the fine should have been far lower than the headline sentence selected by the sheriff.

[39] If the sheriff had considered the culpability was low and the harm at Level A, the consequent harm category was Harm Category 3. Given the factors outlined to the sheriff in terms of the efforts made by the appellant on health and safety, it was submitted that the level of culpability was low. There had been significant efforts made to ensure the health and safety of all residents across a number of areas, as was demonstrated in the narrative and the submissions on behalf of the appellant. While there had been significant efforts to ensure health and safety, they were inadequate on this one, isolated occasion. The incident was properly viewed as an isolated one - with the previous health and safety record being exemplary and the health and safety record in the 6 years following the incident similarly excellent - and above and beyond what is generally required.

[40] The company fell within the micro company bracket, having a turnover of less than £2 million. The category range for a fine for a micro company where the harm category is 3, and the culpability is low, would be a range of fine far lower than imposed by the sheriff. Even if the company were considered to have a medium level of culpability, the fine level would have been in a range far lower than imposed by the sheriff.

[41] There were no aggravating features and substantial mitigation. The fact that the fine would take more than 6 years to pay showed that it was excessive.

[42] The sheriff erred in treating the placing of tape on the sensor as a deliberate act designed to circumvent the risk assessment. The use of tape was a recognised approach in the guidebooks for the sensors (this was an agreed aspect of the plea based on the investigation carried out), and the particular sensor in the deceased's room was not well placed to assist her in her independent but risk-free living. Photographs showed it to be above door height in her room, and inappropriate properly to record movement in a way that promoted her wellbeing. It was a sensor that did not routinely sound when she left her room and did sound when she turned over in bed, and did not sound at other times because her movement was masked by the significant number of soft toys that she liked to keep in bed with her. Moving the deceased to another room, in order to change the sensor or to have her in a room with a different sensor would have been extremely distressing for her. It would have increased the risks of disorientation given her limitations and dementia.

[43] While other residents had left the home through the fire door, none of these incidents had detrimental consequences or led to a risk to their welfare.

[44] There had been no similar incidents of residents being outwith the care home without the knowledge of carers or at night. The care home was graded very highly by the

Care Inspectorate only 2 months prior to the incident, a grading consistent with other prior inspection reports.

[45] Counsel reiterated the various mitigatory factors: the fact that immediate steps were taken to put right the deficiency; the appellant's previous good record; its cooperation with the investigation; the devastating effect of the death on the directors and staff; the unusual and isolated nature of the incident; the fact that the breach was not committed with a view to profit; the early acceptance of responsibility; the length of time taken to bring the case to court; and the personal circumstances of the directors. It was submitted that inadequate weight had been given to the cumulative effect of these various factors.

Decision

[46] The court has given careful consideration to all that has been said on behalf of the appellant, but is not persuaded that the fine was excessive. The sheriff analysed all the relevant features of the case and came to a well-reasoned conclusion. He assessed the level of culpability in light of several indisputable aggravating features: in particular, the fact that the failure properly to assess risk led directly to the deceased's death; that she was a highly vulnerable person for whose specialised care in a safe environment the appellant was wholly responsible; that the appellant failed adequately to address the obvious risks to her safety of leaving her room at night; and the fact that the absence of an alarm on the dining room door was, on any reasonable assessment, a gross failing. The sheriff took full account of all the mitigating considerations. In selecting the level of fine he adopted a nuanced approach based on a sound analysis of the appellant's financial position given the limited information provided to him.

[47] We were referred to the accounts for the year ended 31 March 2022, which had not been before the sheriff. There is nothing in them that detracts from the approach he took. We note, in particular, that the appellant has net assets of £694,196. From the profit and loss account shown to us the total turnover for the 3 months ended December 2022 would appear to be £242,156. This is a significant increase on the same 3 month period in 2021 and 2020, apparently due to a substantial increase in the amount of residents' fees. Accordingly, we are not persuaded that reliance on turnover as opposed to net assets would justify a different outcome.

[48] While the sheriff did not base his approach explicitly on the Definitive Sentencing Guideline issued by the Sentencing Council for England and Wales, he was not bound to do so, particularly since the Guideline was not relied upon by the appellant at the sentencing diet. The sheriff had regard to *HMA* v *Munro & Sons Highland Limited* 2009 SLT 233 and to *Scottish Sea Farms Ltd* v *HMA* 2012 SLT 299 and applied the guidance contained in these authorities.

[49] In any event, there is nothing in the sheriff's approach that is materially inconsistent with the Guideline. In essence, he correctly assessed the level of the appellant's culpability, took proper account of the mitigation, and selected a fine that was appropriate and proportionate in view of the appellant's financial position. We consider that under the Guideline the level of culpability would have been assessed as being at least high and possibly very high. There was arguably a deliberate breach of or flagrant disregard for the law by failing to ensure that an obvious safety measure was working; in this connection we note that the appellant pled guilty to a libel that included their having de-activated the alarm. In answer to questions from the court counsel explained that the alarm had been de-activated for a number of months before the incident. Since the bedroom sensor was also

de-activated the position was that there was nothing to alert the carers on duty to the fact that the deceased had left her bedroom, gone to the dining room and used the dining room fire door to leave the building. There was a significant risk that the deceased would behave in this manner, as the appellant was or should have been well aware. All this points to a high or very high level of culpability on the part of the appellant.

[50] Looking at the factors referred to in step one of the Guideline, the appellant at least fell far short of the appropriate standard by failing to put in place safety measures that are recognised standards in the industry, namely by ensuring that there was an effective alarm on an exit door likely to be used as a route out of the home by a vulnerable resident suffering from dementia. So far as the seriousness of the harm risked by the appellant's breach is concerned, this would clearly be categorised under the Guideline as being at level A since the breach directly caused the deceased's death. The likelihood of that harm arising was high since it was very likely that the deceased would attempt to leave the home during the night by means of the dining room door leading outside. The Guideline next requires the court to consider *inter alia* whether the offence was a significant cause of actual harm. There can be no doubt that the answer to this must be in the affirmative: the failure properly to address an obvious risk directly led to the deceased's death. Such a conclusion would justify the court moving the offence up a Harm Category or moving up the starting point at step two.

[51] Step two under the Guideline requires the court to focus on the organisation's annual turnover to reach a starting point for a fine. In the case of a so-called micro company, such as the appellant, the starting point for a high culpability offence in Harm Category 1 is stated to be £160,000 with a category range of between £100,000 and £250,000. The headline sentence selected by the sheriff falls squarely within that range. The Guideline allows

for upward or downward adjustment from the starting point in view of aggravating and mitigating factors. As we have said, the sheriff took proper account of both types of factor in his approach. The headline sentence he selected was less than the starting point for a high culpability offence and was lower than the mid-point in the category range.

[52] It is important to note also that under steps three and four in the Guideline the court should step back, review, and if necessary adjust the initial fine to ensure that it fulfils the sentencing objectives for the offences. These include ensuring that the fine is sufficiently substantial to have a real economic impact that will bring home to the company's management and shareholders the need to comply with health and safety legislation.

[53] We consider that the fine imposed by the sheriff properly fulfilled the relevant sentencing objectives of punishment and deterrence, that it will have a real economic impact on the appellant, and that it is not in any sense disproportionate in light of the appellant's financial position. In short, when the Guideline is used as a cross-check against the sentence imposed by the sheriff it can be seen that the fine selected was broadly in line with the level of fine that would be appropriate were the Guideline to be applied to the circumstances of the present case. We stress that the Guideline should not be used in a mechanistic manner; it can be used as a broad cross-check against the sentence that would be considered appropriate according to current Scottish sentencing practice.

[54] The appeal is refused.