JUDICIARY OF
ENGLAND AND WALES

R (on the prosecution of Wolverhampton City Council)

V

CUSHMAN & WAKEFIELD DEBENHAM TIE LEUNG LIMITED

SENTENCING REMARKS OF THE HONOURABLE MRS JUSTICE CARR DBE

Introduction

On 23 February 2017 the Midlands region was experiencing a winter storm with significant winds – part of "Storm Doris". At 11.38am that day Ms Tahnie Martin, a young professional woman aged 29 years old and recently engaged to be married, was walking with a work colleague, Ms Raman Sarpal, in Dudley Street next to the Mander Centre, Wolverhampton. She was struck and killed by a large and heavy wooden panel which had been blown off the top of a plant room roof of the nearby Blackrock building forming part of the Mander Centre since 2012 ("the building") by the wind. Other large wooden items had also been dislodged from the same roof and landed in the same area. Despite the brave and sustained efforts of shocked bystanders, Ms Martin tragically died. Ms Sarpal was also knocked to the ground and injured.

Cushman & Wakefield Debenham TIE Leung Ltd (formerly named DTZ Debenham Tie Leung Ltd) ("the Company") is a commercial property and real estate consultant. It had been the managing agent for the building since September 2012. Its responsibilities included identification of the structures and facilities making up the building as necessary for planning and risk assessment purposes. The Company failed to identify two particular brick-built structures on top of the plant room roof ("the plant room roof") which was itself on top of the roof known as Level 6: namely a former ventilation shaft with a substantial wooden louvered hood and a disused water tank topped with a large wooden panel structure. The structures were not inspected or maintained in any way whilst under the Company's charge. They were omitted from maintenance plans. By 23 February 2017 the parts intended to secure the structures to the brick were entirely rotten and/or corroded. When subjected to winds of up to 58 to 59 mph they were simply blown away, with one part (measuring 130cm x 122 cm) ending up on the roof of the O2 building in the Mander Centre and the other larger part (measuring 130cm x 162 cm) striking Ms Martin. An inquest jury concluded that the panel that killed Ms Martin was blown away because of the lack of maintenance which had resulted from wet rot and corroded defective fixings.

The Company now stands convicted on its guilty plea to an offence contrary to section 3(1) of the Health and Safety at Work Act 1974 ("the Act") of failing, on and before 23 February 2017, to conduct its undertaking in such a way as to ensure, so far as was reasonably practicable, that members of the public were not exposed to material risk to their health and safety.

I now sentence the Company on that conviction. A large amount of material has been placed before and considered by the court, including the product of a lengthy health and safety investigation, led by Senior Environmental Health Officer Linda Fletcher, involving multiple schedules and reports.

The Act

S. 3 of the Act imposes a non-delegable duty on employers to conduct their business in such a way as to ensure, so far as is reasonably practicable, that non-employees are not thereby exposed to risks to their health or safety. Risk of injury is an ingredient of the offence, but resulting injury is not (though it can be (non-conclusive) evidence of risk). The risk must be a material risk to health and safety, which any reasonable person would appreciate and take steps to guard against, and not merely trivial or fanciful. Thus s. 3 creates absolute criminal liability subject only to the qualification of reasonable practicability.

Management of the building by the Company

The Company's responsibilities included inspection every six months, raising material defects or wants of repairs with the freeholder, procuring that the property was maintained, repaired and renewed and arranging works, maintenance or repair to the fabric of the building. The freeholder held ultimate responsibility for the asset management strategy and budgetary control.

In 2011 the Company appointed Mr Philip Dutton, who had no formal professional qualifications but who had worked previously as a site manager and then briefly as a plant engineer, as operations manager of the Mander Centre. He was required to and did attend various training courses including a full course on managing safety in property management. He was under the supervision of Mr Andrew King, an associate of the Company with over 25 years' experience in asset and property management. Mr Dutton's role covered overseeing health and safety management of the site, including ensuring that inspections were conducted and where necessary acted upon.

A team at the Mander Centre would complete a daily site safety checklist and a monthly external checklist. Shopping centre management meetings were held about once a month attended by Mr Dutton and Mr King and freeholder representatives and included consideration of maintenance works and health and safety management.

The building was managed within the Company's property and management and health and safety management systems accredited to international standards ISO9001 and in due course OHSAS 18001. There was a workplace health and safety procedure requiring routine inspections, including routine building management safety inspections at least every three months and risk assessments at least every three years.

Mr Dutton was responsible for the routine inspections. Health and safety risk assessments were undertaken by third party well-respected specialists engaged by the Company, namely Bureau Veritas UK Ltd ("BV") and William Martin Compliance Solutions Ltd ("WM"), subject to agreed specifications which included reporting obligations. The specification for WM's work included an expectation that WM would be alert to other areas of health and safety risk and for this to be brought to the Company's attention as appropriate and a requirement that WM would communicate any issues outside the scope of its report/site visit which could pose a wider health and safety risk. WM produced risk assessments on the Mander Centre, including in 2015 and 2016.

The Company also provided surveying services at the Mander Centre on behalf of the landlord, including the carrying out of Planned Preventative Maintenance ("PPM") surveys.

The Company's position is that, prior to this incident, it fully believed that its health and safety risk assessment systems and its maintenance procedures were entirely effective, robust and compliant with all legal requirements.

The incident

I have been referred to a large number of witness statements relating to the incident including from witnesses to the incident itself; firefighters; the operations manager for the Mander Centre; representatives of the building owner; contractors; consultants; senior environmental health officers, surveyors. The full detail is not necessary for present purposes. In summary,:

a) A long section of plinth which should have been securing the water tank cover was found flapping in the wind. It fitted along one edge of the panel that had struck Ms Martin. The wooden cover should have been secured by a hasp and staple arrangement, with the staple screwed to a fixing pad secured to the brickwork below, with the hasp passing over it. A nut and bolt would then pass through the exposed staple to secure the arrangement. However, the hasps and staples were corroded and the supporting timber was visibly rotten. Some pads crumbled to the touch. In some cases the staple had simply pulled out of the rotten pad, removing the wood with it. In other cases, one or more metal components remained.

b) The wooden cover on the ventilation duct had flown a significant distance. It should have been secured to a wooden sill secured to the brickwork below. However, the wooden sill was rotten and the metal fixings corroded.

Mr Bate, an experienced surveyor, found moisture readings from some of the fixing pads for the water tank cover to be "off the scale". He opines:

> "…any reasonably competent person responsible for the maintenance of the building would, on sight of the tank room housing and the redundant vent housing, have been aware of the defective decoration, wet rot in the timber and corrosion in the fixings; quite simply it was obvious to see."

The reason for the wet rot was natural weathering which would have been avoided by normal attention to decoration. Being exposed to weathering at a high point on the building, decoration at least every three years to avoid wet rot decay was required. Mr Bate's analysis based on a three year cycle suggests decoration last took place in 1986; on a five year cycle 1998.

Relevant surveys and works at the property

The Company had multiple opportunities to identify, inspect and commission the necessary maintenance works to the structures on the plant room roof including the following:

a) A 2013 report on "Working at Height" produced by an external provider showed photos of the ventilation duct and water tank in poor condition;

b) A 2014 desktop exercise carried out by one of the Company's inhouse surveyors for the purpose of PPM mentioned the plant room roof and set out planned works to the roof coverings in the bracket of 6 to 10 years. There was no mention of the ventilation duct or water tank;

c) In July 2015 another of the Company's inhouse surveyors visited the building to identify essential works required over the next 5 years, including to bring the building into wind and weather tight condition. Photographs within the resulting report clearly show the water

tank and the ventilation shaft – and in visibly poor condition. Multiple roof works were identified, but none to the plant room roof (or the water tank or ventilation shaft there);

d) Works were carried out in 2016 to replace the wooden doorways on the plant room building immediately below the water tank structure. It would (and should) have been obvious that wooden items on the roof would likewise have needed maintenance, if not more so.

There were also inspections of Level 6 by Mr Dutton and Mr King in 2015, alongside monthly (unrecorded) inspections of the building's exterior. The Company states that such inspections did not normally extend to its roof. There were also 6 monthly inspections which appear to have also gone unrecorded, at least in part.

Access to the plant room roof was controlled by a Permit to Work System. According to Mr Dutton, no such permit was granted in his time at the building and to his knowledge no one ever accessed this roof.

Breaches

The Company is guilty of the following (sometimes overlapping) failures:

a) Failing to identify all structures which needed to be considered, reported upon and maintained;

b) Failing to conduct a suitable and sufficient risk assessment in respect of the structures on the plant room roof which required maintenance to keep them in a safe condition, to react accordingly to such risk assessment and recommend that they be maintained.

c) Failing to devise, implement and properly manage an effective system to ensure that all areas of the building, including structures on the plant room roof, had been identified and were subject to routine assessment/inspection and maintenance as required;

d) Failing to take suitable and sufficient steps to prevent, so far as is reasonably practicable, the fall of any material or object so as to avoid injury to any person;

e) Failing to manage/supervise its staff sufficiently effectively so as to ensure that its statutory duty was discharged.

Remedial steps taken by the Company

Following the incident the Company established a working group to consider improvements to its practices, policies and procedures to ensure that risks arising from structures such as those on the plant room roof could not be missed in future. The outcome of that work included the implementation of building public risk assessments involving additional training for building surveyors and operations managers and those in similar roles; revision of the routine building inspection form; a greater level of audit of external consultancy work; enhanced role profiles for front line operational staff; changes to leadership performance evaluation; amendment of building survey instructions; development of new working procedures to ensure co-ordinated responses to surveys and inspections; improvements to the quality management system; repairs to the building itself.

Victim personal statements

Ms Martin's parents speak of their devastation at the loss of their precious daughter. Ms Martin had a first-class degree, a job she loved at the University of Wolverhampton and had just got engaged, with everything to live for and look forward to. Mrs Martin speaks of rarely leaving the house now and never speaking to neighbours. She relies on medication to sleep and cope with her anxiety. The publicity and press intrusion surrounding the events of the day deeply distressed the family. Mrs Martin misses her daughter every minute of every day, as does Mr Martin. His health and wellbeing have also deteriorated. He has been unable to return to work. Their lives will never be the same.

Mr Lee is the young man who had proposed to Ms Martin whom he describes as kind, funny, caring and great fun to be around with an infectious personality. They had just moved into their first home together. She was his entire world and he has now been left alone. He was unable to work for many months. He has lost his wife to be, an amazing young woman with the whole world at her feet.

Ms Sarpal outlines her leg injuries, which included a deep laceration to her thigh, and continued problems with her right knee where she still suffers pain and swelling. She also speaks of the immense effect of the incident on her and its wider consequences, the full details of which I take into account. As she puts it, how can people not have been safe going about their normal shopping?

Against all of the above, I turn to the framework of the sentencing exercise itself.

Sentencing Council Guideline and authority

I have regard to the Sentencing Council Definitive Guideline on Health and Safety Offences ("the Guideline"), considering the authoritative guidance of the Court of Appeal in *Whirlpool UK Appliances Limited v R (on the prosecution of Her Majesty's Inspectors of Health and Safety)* [2017] EWCA Crim 2186 ("*Whirlpool"*). There reference was made to *R v Thames Water Utilities Ltd* [2015] EWCA Crim 960 where the principles governing the sentencing of very large organisations run for profit as set out in *R v Sellafield Ltd* [2014] EWCA Crim 49 (at [3]) were adopted. The Court in *Whirlpool* addressed in particular the correct approach to sentencing large and very large organisations, and the relevance of the offender's financial circumstances. The decision in *Whirlpool* makes it clear that no two health and safety cases are the same. There is inherent flexibility in the Guideline, which is not a straitjacket. The Guideline provides for very substantial financial penalties in appropriate cases, particularly when the offender is a large or very large organisation. Yet it is "*subtle enough*" to recognise that culpability, likelihood of harm and harm itself should be properly reflected in any fine, as well as turnover (see [42]). I have also considered the recent judgments of the Court of Appeal in *R v John Henry & Sons Ltd* [2018] EWCA Crim 30 and *Faltec Europe Ltd v Health and Safety Executive* [2019] EWCA Crim 520 (*"Faltec"*).

Step 1: Offence category: culpability and harm

As for *culpability*, inspection, risk assessment and maintenance of the building formed part of the Company's core responsibilities. The structures are plain to see on the plant room roof from a wide range of positions on Level 6. Specifically, the water tank is very close to the edge of the plant room roof and extremely difficult to miss from Level 6. Additionally, the structures can be seen clearly from the 9th floor of nearby Mander House on which the Company had a presence. The Company was also in possession of photographs showing the structures.

On the material before me, it is extremely difficult to see how Mr Dutton, Mr King and others at the Company could not have noticed the existence of the structures on the plant room roof at any time between September 2012 and February 2017. If the structures were genuinely not seen and

identified (or noticed in the reports), this would suggest no or only the most cursory safety assessment of the top roof of a large building in a busy shopping centre. If the structures were not seen by them, putting it simply, no one can have been looking at the plant room roof at all. The fact that this was possible highlights starkly the inadequacy of the Company's risk assessment systems and inspection procedures. In the 5 years during which the Company had been managing agent for the building, no inspection or maintenance of any sort was carried out on the structures on the plant room roof. This was a serious failure.

Proper such systems and procedures were essential to ensure that the building was in a safe condition and not a risk to the safety not only of those working in and on it but also to those in its vicinity, such as Ms Martin. The Company placed too much reliance on Mr Dutton, given his limited previous experience in similar roles, of which the Company would (or should) have been aware, and he does not appear to have been closely monitored. There was no basis for his apparent assumption that the plant room roof was a flat roof with no structures or plant on it. The assumption was never checked, ignoring for a moment the fact that it was clearly and obviously wrong. It was at odds with the material available. There is also no question but that access to the plant room roof could and should have been gained through the Permit to Work/Access scheme.

It is right that no inhouse or third party surveyor expressly drew attention to the presence or dangerous condition of the structures despite reporting obligations. The Company can point to a degree of reasonable reliance on this factor, though complicated by the fact that access to the plant room roof may not have been available without a permit and accepting always that it over-relied on third party advisors.

However, and in any event, reports were produced which showed the structures and in poor condition. The Company was in possession and aware of these reports which identified those structures and was on notice, in 2015 for example, of the need for doors and other structures on Level 6 to be repaired. The building contractor engaged to carry out works from time to time at the building (Bowmer & Kirkland Ltd ("B & K")), as with other consultants, contractors and surveyors, was never asked to survey or work on the plant room roof. In the words of Lord Hoffman in *R v Associated Octel Co Ltd* [1996] 1 WLR 1543 (at 1547F-H), the Company did not "stipulate for whatever conditions are needed to avoid …risks [to people's health and safety] and are reasonably practicable".

Quarterly routine building management safety inspections were not undertaken and the adequacy of such assessments as were carried out was not checked. The investigation after this incident reveals historic reports suggesting that there was a backlog of routine and cyclical maintenance, in part perhaps to due to a lack of enthusiasm on the part of a previous landlord to commit funds. I emphasise that no one suggests that this was a case of disregard or disinterest on the part of the Company to maintenance issues: the Company did react to surveys by the carrying out of necessary identified works, but not in every respect and sometimes many years later. Some items required enforcement action in the form of Improvement Notices issued in March 2017. A report prepared by the Company following the incident identified at least 50 urgent roof repair items.

The Company submits that this is a low or "low end of medium" culpability case, given its significant efforts to address risk (though they were inadequate on this occasion) and that this was an isolated incident. Emphasis is placed on the use of appropriately qualified specialists, none of whom identified the problem in question, and the Company's belief that Mr Dutton was undertaking his role with skill and care.

In my judgment, an assessment of culpability at that level would not be right or fair. The Company failed in relation to inspection and maintenance of the structures on the plant room roof and in its supervision and monitoring of Mr Dutton throughout its many years as managing agent of the building. The remediation steps taken demonstrate what systems and procedures could easily have been in place. The failings were serious. Set against that is the fact that there were systems in place by which the Company intended (and believed) the building to be safe. Those systems have proved to be inadequate so far as the relevant structures are concerned, and there was a lack of full implementation and proper recording. The Company's belief as to Mr Dutton's performance does not address the fact that, as the Company ought to have realised, he was not adequately experienced or qualified to be entrusted with the task in hand, at least not without proper supervision.

This offending cannot fairly be categorised as a single failure or one which occurred in an otherwise comprehensive and appropriate system of inspection, risk assessment and maintenance. Evaluating the case as a whole and conducting a balancing exercise, it falls to be treated as medium culpability offending but towards the high end of that category.

As for *harm*, the offence is in creating a risk of harm. The assessment of harm requires a consideration of both the seriousness of the harm risked by the breach and the likelihood of that harm arising. Three large structures were dislodged, and it was entirely possible for more than 1 of them to have reached street level. It is common ground that the risk was of the highest level A (death).

This is not a case where there is scientific evidence on which to base an analysis of the likelihood of such harm arising (cf *Faltec*). The winds in question were typical of a winter storm (of middle order) such as will be found in Wolverhampton every year or two. The health and safety obligation is aimed at ensuring that buildings are safe, not only in mild, but also stormy conditions. I reject the Company's submission that that the likelihood of such harm being caused by the Company's failure to risk assess, recommend maintenance and supervise Mr Dutton properly was only low. There was a strong likelihood that Mr Dutton, through inexperience and/or lack of adequate supervision, would miss a danger of the type presented by the structures on the plant room roof. The involvement of third parties or inhouse surveyors served to reduce the risk of harm, but only to a limited extent in circumstances where they were never directed in terms to consider those structures and where access to the plant room roof may not have been immediately available without a permit.

I conclude that the likelihood of level A harm arising as a result of the Company's breach was medium. Thus this was, on initial categorisation, harm category 2.

In assigning the final harm category, I consider whether the offence exposed a number of workers or members of the public to harm and whether the offence was a significant cause of actual harm, namely one which more than minimally, negligibly or trivially contributed to the outcome. These are factors to be considered in the round in assigning the final harm category. If one or both of these factors apply, the court must consider either moving up a harm category or substantially moving up within the category range.

Here a significant number of members of the public were put at risk of death or grave injury. A viewing of the CCTV footage available on the day makes it chillingly clear quite how busy the area was with shoppers. Within the period of approximately 5 minutes before the incident and in the area where Ms Martin was struck alone, 88 adults, three teenagers and ten small children walked through. Several groups of pedestrians, including the elderly and children, passed through the

location where Ms Martin was struck in the few minutes before 11.38am. And the offence caused actual harm of the gravest kind to Ms Martin and serious physical and related injury to Ms Sarpal.

The very strong presence of both features means that an upward move to category 1 harm (and significantly so) is clearly called for.

Step 2: Starting point and category range

For a "large" organisation, defined as an organisation with turnover or equivalent of £50million and over, the starting point for medium culpability and harm category 1 is £1.3million with a range of £800,000 to £3.25m. There is no definition of what is to be treated as a "very large organisation" for the purpose of the Guideline. In *R v Thames Water Utilities Ltd* (supra) the Court saw no advantage in any particular definition, for example by reference to turnover exceeding £150million per year.

Here, the Company's turnover for the year to 31 December 2018 was £141.8million (unaudited); £124million for the year to 31 December 2017 and £117.33million for the year to 31 December 2016. These levels of turnover are very significantly above the starting point adopted in the Guideline of £50million and increasing.

Despite this, the Company can properly be treated as a "large" organisation for the purpose of the Guideline, which expressly contemplates a "large" organisation having turnover beyond £50million, indeed "greatly" beyond. However, I consider it appropriate to rise within the category range to take account of the fact that the Company's turnover is so significantly over the £50million mark (albeit not on any strict mathematical or extrapolated basis).

With this in mind, and on the basis of my assessment of culpability and harm, I adopt a starting point - before taking into account aggravating and mitigating factors - of **£2.5million**.

There are no aggravating factors. The Company has significant mitigation available to it. It has no previous convictions; it has taken considerable voluntary steps to remedy the problem as set out above; it has provided a high level of co-operation with the investigation, beyond that which will always be expected; it manages some 650 properties across the UK and has a good health and safety record with no record of previous enforcement action; it endeavours to place health and safety at the forefront of its practices; it has accepted its criminal responsibility at the earliest possible opportunity, informing Ms Martin's family before proceedings even commenced.

Taking all these factors into account, I make a downwards adjustment for the available mitigation to reach a figure of **£2million** before turning to step 3.

Step 3: proportionality to overall means

I ask myself then whether the proposed fine based on turnover is proportionate to the Company's overall means, taking into account s. 164 of the Criminal Justice Act 2003 which requires that the fine must reflect the seriousness of the offence and that the court must take into account the financial circumstances of the offender. The level of fine should reflect the extent to which the offender fell below the required standard. It must be sufficiently substantial to have a real economic impact which will bring home to both management and shareholders the need to comply with health and safety legislation. The profitability of an organisation will be relevant. Guidance on the correct approach can be found in *R v Tata Steel UK Ltd* [2017] 2 Cr App R (S) 29 at [52] to [59] and *R v NPS London Ltd* [2019] EWCA Crim 228 at [15] and [16].

For the Company alone, net profits were £13.4m in 2017, reduced to £6.6m only by an exceptional item made up mostly of restructuring costs. It is successful and with increasing turnover. There is no suggestion by the Company that any fine should be reduced because of any lack of resource, despite the fact that, for example, the Company's balance sheet for 2017 reflects a net deficit. This approach reflects the fact that the Company receives support from a linked company, DTZ Worldwide Limited, (as recorded in the Company's accounts) and adequately addresses the broad position of the Company as part of a larger corporate group.

Given the adjustment for turnover already made in step 2, I do not consider that it is necessary to move upwards again in order to achieve a proportionate sentence which brings the position home to the Company and its directors. As set out above, the Company has taken active steps to remedy its failures and has an otherwise good health and safety record. I am satisfied that the message is appropriately understood at this level of fine at £2million.

There are no factors that would warrant any adjustment as identified in steps 4 and 5 of the Guideline.

Guilty plea

The only remaining matter to consider is the question of any potential reduction for a guilty plea in accordance with s. 144 of the Criminal Justice Act 2003 and the Sentencing Council Guideline on Reduction in Sentence for a Guilty Plea. The Company entered its plea at the first possible opportunity and is entitled to a full one-third credit accordingly.

Compensation and costs

There has been no application for a compensation order and I make no order for compensation. The Company has agreed to pay and paid the prosecution costs in the sum of £375,000. The victim surcharge order will apply as appropriate.

Conclusion

For the reasons set out above, I impose a fine of **£1,333,000** to be paid within a period now to be fixed. This is in my judgment a level of fine which represents both the seriousness of the offence and the extent to which the Company fell below the required standard, together with the relevant financial circumstances. It is also a proportionate one which is sufficiently substantial to meet the objectives of the health and safety legislation and sentencing regime.

None of this can return Ms Martin to her family, fiancé, friends and colleagues (or turn the clock back for Ms Sarpal). I conclude by expressing once more condolences and sympathy to them. It is to be hoped that such a tragedy in such circumstances never happens again.

2nd July 2019