Courts and Tribunals Judiciary

IN THE CENTRAL CRIMINAL COURT

7 February 2023

Regina (Office of Rail and Road)

v.

SIEMENS PLC

Sentencing Remarks

HHJ Dhir KC

Introduction

1. This case concerns the death of Ian Parker in a tragic accident on 13 June 2017. Mr Parker was working at the premises of the defendant company, Siemens Plc, when a 650kg traction motor fell on him and killed him. This was an accident which the defendant ought to have prevented.

2. Mr Parker was 58 years old when he died. He leaves behind two sons, Luke Parker, who is now 33 years old and Matt Parker, who is now 31 years old years old, as well as his three grandchildren and his daughter in law. The accident ended Mr Parker's life and brought grief and misery to the lives of his family and friends. His daughter in law, Heather Parker, read out the victim impacts statements on behalf of the family. She said:

'*As you can imagine the impact on all our lives has been traumatic and devastating… when this happened all our imaginations went off the scale …..thinking why? what? how?*

Our father was literally crushed to death.…we couldn't even say our goodbyes to [him]… The funeral directors advised us not to see him as he was so disfigured... It was 2 months before we were allowed to have the funeral.

Mrs Parker went on to say:

Our lives have never been the same. We miss him terribly. The void and emptiness in all our hearts we will never get back. We can't go anywhere or do anything with him ever again…

We all felt and still feel total devastation …Our lives will never be the same again.

3. No sentence which this court could impose could ever make up for the loss of Mr Parker to his family and those who knew him. The duty of this Court is to impose a fine on the defendant which takes account of the various factors identified in the relevant sentencing guidelines applicable to the defendant's conduct in committing this offence.

The Offence

4. The defendant has pleaded guilty to one charge of contravening a health and safety regulation, contrary to section 33(1)(c) of the Health and Safety at Work etc Act 1974 ("the Act"). The defendant pleaded guilty at the first opportunity, on 19 October 2022 in the Westminster Magistrates' Court.

5. The particulars of the charge are that the defendant, on or before 13 June 2017 at Siemens Train Care Facility, 203 Old Oak Common Lane, White City, London W3

7DX ("the Depot"), being an employer within the meaning of the Act, failed to discharge the duty imposed on it by section 3(1) of the Act, in that it failed to conduct its undertaking, namely the removal of traction motors from Desiro 360/2 trains at the Depot, in such a way as to ensure, as far was reasonably practicable, that persons not in its employment who may be affected thereby, including Mr Parker, were not thereby exposed to risks to their health and safety.

6. As is stated in the sentencing guideline, health and safety offences are concerned with failures to manage risks to health and safety and the offence is in creating a risk of harm.

The Accident

7. Mr Parker was a self-employed contractor who worked as part of a team of contractors who formed the Heavy Overhaul Team ("the Overhaul Team") at the Depot. The Overhaul Team were tasked with removing several traction motors for routine refurbishment from electrically powered trains which operate on the Heathrow Express. The traction motors were to be lifted by a crane.

8. The motor was connected to the bogie frame by four mounting bolts, which were held in position by mounting sleeves. There were also two safety plates below the motor to prevent it falling if the mounting bolts failed. What should have happened is that the mounting bolts, the mounting sleeves and the safety plates should not have been removed until after the crane had taken the weight of the motor.

9. Unfortunately, Mr Parker removed the mounting bolts, the mounting sleeves and the safety plates before the motor had been properly supported by a crane. It is not known when Mr Parker removed the bolts, but it is agreed that it is highly likely that they were

removed immediately before the accident. Mr Parker was in an inspection pit underneath the motor when it fell.

Step 1: Culpability

10. Step 1 in the sentencing guidelines is to determine the offence category. The first part of that step is to determine the defendant's culpability. The parties are agreed that this case falls within the medium culpability category. The relevant culpability factors for this category are:

> "Offender fell short of the appropriate standard in a manner that falls between descriptions in 'high' and 'low' culpability categories
>
> Systems were in place but these were not sufficiently adhered to or implemented"

11. However, the prosecutor, the Office of Rail and Road ("the ORR"), suggests that this case may fall in the upper end of that bracket and that the Court may wish to consider high culpability as an alternative categorisation. The culpability factors for the high culpability category are as follows;

> "Offender fell far short of the appropriate standard for example, by:
>
> - failing to put in place measures that are recognised standards in the industry;
> - ignoring concerns raised by employees or others;
> - failing to make appropriate changes following prior incident(s) exposing risks to health and safety;
> - allowing breaches to subsist over a long period of time.

Serious and/or systemic failure within the organisation to address risks to health and safety"

12. The ORR suggests that it may be that the defendant fell far short of the appropriate standard by failing to put in place measures which are recognised standards in the industry and/or failing to make appropriate changes following a prior incident exposing risks to health and safety.

13. It is necessary, therefore, to look at the nature and scope of the defendant's failings. As to that, certain matters are common ground. The parties agree that:

(1) The task was not unusually specific or complex. Rather, it was dangerous and required a degree of technical skill.

(2) The Overhaul Team was capable of removing the traction motor and qualified to do so. Insofar as the removal was "mechanical work", it was work of a kind regularly undertaken by the Overhaul Team.

(3) The defendant had a defined working procedure for the task in question, which was contained in its Vehicle Maintenance Instructions ("the VMI"). All members of the Overhaul Team had access to the VMI on the defendant's computer system, although one member of the team (not Mr Parker) had difficulties logging in to it.

(4) The VMI was underpinned by a hazard risk assessment which was conducted when it was first developed in order to ensure that the VMI set out a safe method for the removal of the traction motor. That risk assessment identified various risks associated with the task, including moving trains, work under trains, crush hazards and the use of lifting equipment.

(5) If Mr Parker had been subject to appropriate supervision to ensure that he followed the procedure set out in the VMI as required, he would have been able to remove the traction motor safely.

(6) However, there was not a clear allocation of responsibility for supervision of the task of the removal of the traction motors on this occasion. This led to a situation in which Mr Parker was able not to follow the procedure set out in the VMI.

14. I agree that these matters place the defendant's offending in the medium category for culpability. In the words of the guideline, systems were in place, but these were not sufficiently adhered to or implemented.

15. The ORR contend that the defendant's culpability was increased by two factors. One factor is that there was an absence of adequate supervision. That, however, is not a factor which adds anything of substance to the common ground which I have already set out, since it is admitted that there was a failure in the supervision of the task. There may be disagreement between the parties about what would have been adequate supervision, but both parties agree that the defendant failed to provide adequate supervision.

16. The other factor is that the ORR contend that the Overhaul Team, and the operator of the lift, Mr Patten, were not competent to carry out the required tasks. The ORR say this for the following reasons:

(1) A lack of previous experience on behalf of both Mr Patten and the Overhaul Team.

(2) A lack of specific training for both Mr Patten and the Overhaul Team. The ORR say that both task-specific training and assessment were required and that, in order to conduct the lifting operation, Mr Pattern required specific information, instruction and training on the removal of traction motors.

(3) The Safety Critical Assessments which the members of the Overhaul Team had conducted (in "Major overhaul of vehicle components" and "Wheel and bogie change") were, say the ORR, generic and unsuitable as a standalone assessment to measure the team's, or an individual's, competence for the task.

(4) The absence of a specific, rather than generic, lift plan.

17. The defendant does not accept that the Overhaul Team were not competent to carry out the task. Accordingly, I raised with the parties whether it was necessary to hold a *Newton* hearing. Both parties urged me not to hold a *Newton* hearing, and I have not done so.

18. Insofar, however, as the ORR contend that the nature or scope of the defendant's offending behaviour was more extensive than is admitted by the defendant, I could only accept that submission if I were sure that it was right. I have not heard oral evidence from expert witnesses on this disputed issue and, in all the circumstances, I cannot be sure that the defendant's offence included, in addition to failing adequately to supervise the Overhaul Team, giving the task of removing the motors to a team who were not competent to perform it. I note, in particular, that, as I have already said, it is common ground that the Overhaul Team was capable of removing the traction motor and qualified to do so and that, insofar as the removal was "mechanical work", it was work of a kind regularly undertaken by the Overhaul Team.

19. Moreover, it may well be that, even if I had accepted the ORR's contention, that would have made no material difference to the sentence which I am about to impose. The allegation that the Overhaul Team were not competent to remove the traction motor can be seen as another way of saying that the defendant did not, as it admits, do enough to bring home to them the need to follow the correct sequence when removing the traction motor.

20. The ORR also relies on a prior incident, namely an accident which had occurred at the defendant's Neville Hill depot in Leeds on 1 June 2017. The ORR contends that the Neville Hill incident exposed risks to health and safety and that the defendant failed to make appropriate changes following that incident.

21. In fact, however, there was a briefing at the Depot on the morning of 13 June 2017 about the Neville Hill incident. Mr Patten and his supervisor, Mr Sharma, were among those who attended that briefing. Indeed, Mr Patten signed a briefing note which stated, amongst other things, that "All personnel carrying out lifting operations are required to complete a lifting plan prior to the lift taking place."

22. Despite that, Mr Patten did not complete the generic lifting plan referred to in that briefing note before the lifting of the traction motor began. He said that his intention was to complete the plan as he was doing the lift. In its written submissions, the ORR has criticised this as illustrating, in particular, a lack of monitoring and supervision. As such, it forms part of the admitted failure to supervise the lifting operation adequately.

23. In all the circumstances, I do not consider that the defendant's failings rose to the level indicated by the culpability factors in the high culpability category in the guideline. I will sentence the defendant on the basis that its culpability fell squarely within the medium category.

Step 1: Harm

24. The guideline requires, in the first instance, an assessment of the seriousness of the harm risked and the likelihood of harm arising. It is agreed that the seriousness of harm risked, i.e. death, was at the highest level, i.e. level A, which includes death, impairment resulting in lifelong dependency or significantly reduced life expectancy. As to likelihood of harm, the ORR submits that the likelihood of harm was high, whereas the defendant submits that it was low. I note, however, that in its case summary of 2 July 2021, the ORR submitted (at paragraph 11.1(ii)(c)) that the likelihood an accident occurring was medium.

25. I note also that the likelihood for this purpose in the guideline is not the likelihood of some harm arising, but the likelihood of level A harm arising. As to that, I note also that:

    (1) At the time of the accident, the defendant employed about 950 people at 13 train care facilities across the United Kingdom to maintain fleets of trains for seven train operators.

    (2) There was no evidence before me of any previous (or subsequent) accident at any of those facilities involving level A harm.

26. In those circumstances, I cannot be sure that the level of harm arising was any higher than low.

27. A low risk of level A harm arising places the harm in category 3. However, the guidelines then require me to consider two other factors. One is whether the offence was a significant cause of actual harm. It is admitted that the offence was a significant cause of Mr Parker's death.

28. The other factor is whether the offence exposed a number of workers or members of the public to the risk of harm. The offence did not expose members of the public to harm. It did expose some workers to harm, namely those workers who went into the inspection pit when the traction motor was being removed. That included the three other members of the Overhaul Team and a few others who went into the inspection pit to try to assist Mr Parker, at a time when there was a second traction motor above the pit whose mounting bolts had also been removed.

29. It was common ground that this factor only applied if a significant number of workers were exposed to harm, although the word "significant" does not appear in the guideline. The parties disagreed about whether the number of workers exposed to harm was significant. In my judgment, where the harm concerned is death, even a small number can be significant.

30. I am required to consider these two factors in the round in assigning the final harm category. If either or both of these factors are present, I have to consider either moving up a harm category or substantially moving up within the category range. The defendant accepts that it would be appropriate for me to move up to harm category 2, and I do so.

Step 2: Starting Point and Range

31. For large organisations, i.e. those with a turnover or equivalent of £50 million and over, the guideline states that the starting point in a case of medium culpability and category 2 harm is £600,000, with a range from £300,000 to £1,500,000.

32. However, the guideline also states, under the heading "Very large organisation", that "Where an offending organisation's turnover or equivalent very greatly exceeds the

threshold for large organisations, it may be necessary to move outside the suggested range to achieve a proportionate sentence."

33. It is agreed that the defendant is a very large organisation. Its turnover was £756m in the year to 30 September 2019, £599.3m in the year to 30 September 2020 and £524.5m in the year to 30 September 2021. I have been sent an amended schedule with updated profit and loss amounts for the years 2019- 2022 and I have taken them into account. The defendant submits that I should not increase the sentence by reason of the fact that the defendant is a very large organisation. The defendant relies for this purpose on the sentencing remarks of HHJ Blacksell QC when sentencing Network Rail. However, as the Court of Appeal explained in *R v Sellafield Limited* [2014] Env. L.R. 521, Network Rail is a "not for dividend company" and is quite different from a commercial company such as the defendant.

34. I have had regard to the principles applicable to sentencing very large organisations set out in *R v Places for People Homes* [2021] EWCA Crim 410 and in *R v Sellafield Limited*. I consider that it is appropriate to take a starting point which is outside the range for large companies. I propose to use the figure of £2,400,000, which I consider is proportionate to the defendant's means and sufficiently large to constitute appropriate punishment and to bring home to management and shareholders the need for regulatory compliance. I will address the conduct of the defendant's management in the context of mitigation.

Step 2: Aggravating and Mitigating Factors

35. The only aggravating factor relied on by the ORR is that the defendant had two previous convictions, relating to incidents in 2009 and 2014, one of which resulted in the death of an employee and the other in a broken ankle. However, those incidents both occurred

in the defendant's wind power division, which reduces their significance in the present case, and they have to be balanced against the fact that the defendant has no previous convictions in respect of its rail operation, substantial though that is.

36. As for mitigating factors, it is agreed that the defendant: accepted responsibility for its failings at the outset and made relevant admissions in July 2018; has voluntarily taken steps to remedy the problems identified; and has effective health and safety procedures in place.

37. There is a dispute whether another potential mitigating factor applies, namely whether the defendant displayed a high level of co-operation with the investigation, beyond that which will always be expected. As to that:

    (1) The ORR complains that the defendant did not inform the investigating inspector of the Neville Hill incident. On the other hand, the defendant did report the Neville Hill incident to the ORR and it came to the attention of the inspector in October 2017.

    (2) In contending that its co-operation extended beyond that which is expected, the defendant relies on the fact that it accepted failings before proceedings were commenced. However, acceptance of responsibility is a separate mitigating factor and I must avoid double-counting.

38. Taking all these matters into consideration, the defence say the starting point ought to be reduced by 15% to reflect the mitigating factors. Having considered all the matters carefully, I consider that the fine should be reduced, from the starting point of £2,400,000 to £2,100,000.

Step 3: Proportionality

39. The next step in the guideline is check whether the proposed fine based on turnover is proportionate to the overall means of the offender. The guideline states, amongst other things, that "The court should examine the financial circumstances of the offender in the round to assess the economic realities of the organisation and the most efficacious way of giving effect to the purposes of sentencing."

40. For this purpose, the guideline states that, "Particular attention should be paid to turnover; profit before tax; directors' remuneration, loan accounts and pension provision; and assets as disclosed by the balance sheet." but neither party relied on any of these matters, other than turnover and profit, in the note which they prepared for the hearing, following my request for a joint statement of matters agreed and not agreed.

41. The only aspect of step 3 which was addressed in that note concerned the statement in the guideline that "The fine 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." In relation to that:

(1) The defendant submitted that its management was very much aware of the incident and of the need to comply with health and safety regulation. I have dealt with that issue in the context of mitigation.

(2) The ORR noted that the defendant had not made provision in its accounts for the fine which I am about to impose and speculated that the defendant's shareholders were unaware of the incident. The defendant submitted that it was not required to make such provision and further submitted that its shareholders were aware of the incident. I consider that the question whether such a provision ought or ought not to have been made is immaterial to the decision which I have to make and that the guidelines do not require me to determine, let alone

speculate, whether any or all of the defendants' shareholders have actual knowledge of the incident on 13 June 2017.

42. Accordingly, I do not consider that any adjustment is required to the fine in step 3.

Steps 4 and 5

43. It is agreed that steps 4 and 5 are irrelevant in this case.

Step 6: Reduction for Guilty Plea

44. It is agreed that the defendant's guilty plea at the first opportunity means that I should reduce the fine by one third. I reduce the fine to £1,400,000.

Steps 7: Compensation and Ancillary Orders

45. I am not asked to make an order for compensation.

46. I am asked to make an order that the defendant pay the ORR's cost, in the amount of £99,284.84. This application is not opposed and I make the order sought.

Steps 8 and 9: Totality and Reasons

47. Since there is only one charge, I do not have to consider the totality principle.

48. I am obliged to give my reasons and I have endeavoured to do so in these sentencing remarks.

Conclusion

49. I impose a fine on the defendant in the amount of £1,400,000.

50. I order the defendant to pay £99,284.84 to the ORR in respect of the ORR's costs.

51. I am grateful to all counsel and solicitors for their considerable assistance in this case. I am also grateful Heather Parker, who on behalf of Mr Parkers' family, told the Court about the lasting and life change impact