JUDICIARY OF ENGLAND AND WALES

R (Office of Rail and Road)

-v-

(1) Transport for London
(2) Tram Operations Limited

<u>Sentencing Remarks of Mr Justice Fraser</u>

The Central Criminal Court

27 July 2023

1. Both the defendants, Transport for London ("TFL") and Tram Operations Ltd "TOL"), pleaded guilty in June 2022 to health and safety offences under section 3 of the Health and Safety at Work etc Act 1974, which were prosecuted as a result of the Croydon tram disaster. That event was a significant and tragic transport catastrophe. Each of the defendants have lodged extensive written material in advance of the sentencing hearing, including witness statements and authorities, and made oral submissions in mitigation. I have taken all of those into account, although I do not recite them separately in these remarks. I also remind myself that any findings of fact that I make which are adverse to the defendants must be made by considering the criminal burden of proof. TFL was charged with the offence between 27 June 2008, the date it acquired its interest in the tram network, and 9 November 2016. TOL was charged with the offence between 10 May 2000 and 9 November 2016.

2. At a few minutes after 0600 hours on 9 November 2016 a tram on the Croydon tram network, tram 2551, which was being driven by Mr Alfred Dorris, entered the Sandilands' tunnel complex travelling in the direction from Lloyd Park towards the Sandilands junction, on what is called Route 3. As a result of what happened, tram 2551 was going simply far too fast when it entered the Sandilands curve, which is a sharp left hand bend just before the junction. Its wheels lifted, and the tram overturned and derailed, at very high speed. The effects of this were catastrophic. Passengers described being thrown through the air and tossed about in the tram cars. Seven passengers lost their lives, having been thrown through the air inside the tram, through the glass windows of the tram (those windows not being made of impact-resistant

glass) or doors that were torn off, and then being trapped and crushed under the tram itself, which continued along on its side before it came to a stop. 19 other passengers suffered life-changing injuries, and of the total number of 69 passengers in tram 2551, only one escaped injury.

3. Mr Dorris was also charged as well as TFL and TOL. He pleaded not guilty and was therefore tried here at the Central Criminal Court. He was acquitted by the jury on 19 June 2023 after a long trial, and that trial had the benefit of hearing a great deal of evidence and expert analysis about how the disaster had occurred, and why.

4. The weather that winter morning was extremely bad with heavy rain, and the tunnel was said by witnesses to be "darker than usual". The lighting in the tunnel was extremely poor and was said by a TFL witness to be "past its serviceable life". This is because water had entered the electrics and the system did not work as intended, and had not done so for many years. Additionally, there were a very large number of lights that had shorted out, or failed, and these had just not been replaced. There were no signs or other visual aids to drivers in the tunnel, which is the longest tunnel on the network. The drivers were trained to use gaps in the tunnel as braking points, but in the darkness these were not visible. Mr Dorris had always said, from the immediate aftermath of the crash when he was rescued and consistently afterwards, that he had become disoriented in the tunnel and had thought he was travelling in the opposite direction. Both the prosecution and the defence called very highly qualified and experienced experts, many of them professors and all of them leaders in their field, and during the trial these experts agreed a number of extremely important points. They agreed that driver disorientation was the most likely cause of the tram driving at far too high a speed for the curve.

5. The experts in the trial also agreed that the assorted defects and issues within the tunnel including the defective lighting contributed to the driver's disorientation whilst he was driving the tram. This type of disorientation was something that had occurred to a number of other drivers over the years, and this had occurred before on several occasions including within the Sandilands tunnel itself. Disorientation was also something that had been anticipated by a senior engineer on the network as long before as 2007. That engineer, Mr Snowdon, wished to have extra signage and other measures installed to improve the visual cues within the tunnel, and he thought that disorientation by drivers was a potential issue, particularly in darkness. He gave that advice to TOL the operating company, to TFL's predecessor (as TFL acquired its interest in the network in 2008) and to the rail regulator. He repeated his views in 2008. As Mr Snowdon explained at Mr Dorris' trial, nobody was particularly interested, and he retired in 2008. Nothing was done at all as a result.

6. There had also been a significant "near miss" on the network at the very same location on 31 October 2016. A tram driven by a different driver took the same curve far too fast, but fortunately not quite fast enough to overturn. The wheels lifted off the track and passengers at the time described their terrifying journey as like being on a roller coaster at Alton Towers. Some of them said in texts and posts afterwards that they thought they were going to die. That event was promptly reported to TFL in an email by a passenger that same day. I shall refer to this as "the warning email" and return to what occurred as a result later in these remarks.

7. There is no doubt that Mr Dorris made a human error, and that had terrible consequences. The Health and Safety Executive ("the HSE") issued a guidance document entitled "Reducing error and influencing behaviour" which is called HSG48, and its 2nd edition was published in 1999. It states:
"**Human failure and accidents**
Over the last 20 years we have learnt much more about the origins of human failure. We can now challenge the commonly held belief that incidents and accidents are the result of a 'human error' by a worker in the 'front line'. Attributing incidents to 'human error' has often been seen as a sufficient explanation in itself and something which is beyond the control of managers. This view is no longer acceptable to society as a whole. Organisations must recognise that they need to consider human factors as a distinct element which must be recognised, assessed and managed effectively in order to control risks."

8. Another HSE guidance document called HSG65 (2nd edition published in 1997) states:
"**Prime responsibility for accident and ill health prevention rests with management**
Accidents, ill health and incidents are seldom random events. They generally arise from failures of control and involve multiple contributory elements. The immediate cause may be a human or technical failure, but they usually arise from organisational failings which are the responsibility of management."

9. As these publications make clear, although the immediate cause of the disaster was the human failure by Mr Dorris, there were failures of control and multiple contributory elements that caused the disaster.

10. However, one important point became clear during that trial. There was very little credible evidence by the close of the trial that Mr Dorris had fallen asleep at the controls, a theory that emerged very shortly after the disaster itself and one that has persisted for years. That theory was no longer supported to any appreciable degree by the prosecution experts, and was also contradicted by the number of drivers who had also become disorientated, and the near misses on the network, prior to this disaster, direct evidence of which was heard by the court and considered by the experts. It was also contradicted by the data evidence of what Mr Dorris in fact did whilst at the controls in the seconds leading up to the derailment. The tragic reality of this disaster is that it is a salutary example of what the HSE was referring to in its publications.

11. Mr Dorris' driving that morning was not assisted by the fact that the speedometer on tram 2551 was found to be underreporting, which means it showed a speed consistently about 10 kph slower than the true speed of the tram. Therefore when he thought he was going at 69 kph, the speed shown on the speedometer, which was well within the speed limit of 80 kph in the tunnel that morning, the tram was actually travelling at 79 kph. Before that day, Mr Dorris had an exemplary driving record, and was a careful driver who took pride in his job. He was one of the network's best and safest drivers. The derailment that morning could have happened to any of the drivers on the network; it just happened to be him.

12. The court has heard victim impact statements from many of the victims of the crash, as well as from the families of those who were killed. The administration of justice, and sentencing, must be objective and must put emotion entirely to one side. However,

it is only right to acknowledge the considerable human impact the Croydon tram disaster had on so many people, the passengers who were injured, their families, and in particular the families and friends of those who were killed. They were, in alphabetical order: Dane Chinnery; Donald Collett; Robert Huxley; Philip Logan; Dorota Rynkiewicz; Philip Seary; and Mark Smith. Each of them was simply going about their normal, everyday and early morning business, heading to work on the tram. All their futures ended that morning and their families have been left bereft.

13. Neither TFL nor TOL have been charged with specifically causing their deaths, and I do not sentence either of those defendants as though they were guilty of more serious criminal offences. However, the periods which the charges on the indictment cover are measured in years, and the harm that was risked and caused by the breaches of duty by each of TFL and TOL was of the highest, namely risk of death and serious injury. Those risks came to their dreadful conclusion on the morning of 9 November 2016.

14. To the credit of both defendants they pleaded guilty at an early stage, and this will result in a reduction of the fines I impose this morning. Also, neither of them was responsible for the very considerable delay that occurred prior to each of them being charged, and I take that into account too. I also take into account that the fine I am going to impose upon TFL will be paid by public money, and that TOL, a member of First Group, may simply increase fares paid by passengers to travel. So one way or another, it may be the wider public who bear the brunt of these fines in an indirect way. However, the only sentences that can be passed upon them are fines, and this is the only way that the criminal law can deal with corporate defendants. I would not wish any of those injured, or the families of the deceased, to conclude that financial penalties are thought by the court to equate to their loss in some arithmetical way. The court is well aware that no sentence it can impose upon either corporate defendant can ever remedy what has occurred.

15. TFL was responsible for the infrastructure of the tram network, and TOL responsible for running the tram company. TOL employed Mr Dorris and all of the other drivers. As a result of the breaches by each of TFL and TOL, both passengers and also drivers were exposed to significant risks of serious injury and death over a long period of time. The prosecution maintain that there were many opportunities presented over the years to each of TFL and TOL to consider the risks that were presented, assess and analyse them, and then take reasonably practicable steps to reduce those risks. I agree with that characterisation. Mr Snowdon and his prescient point of view in 2008 is but one example of this. Nobody thought that trams could or would derail at high speed; Commonsense suggests this is obvious. The risk of a fatality was assessed by one assessment as being 1 in a 150 years; I am not sure how that could ever be a sensible assessment. The complacency with which the defective lighting, inadequate signage and lack of visual cues within the tunnel seem simply to have been accepted as facts of life is disturbing.

16. I am not going to lengthen these remarks by reciting all the different features brought to the court's attention by the prosecution in their sentencing document, but I take them into account. The core failure was not even having a risk assessment performed. This was a joint failure. Both TFL and TOL had safety obligations, and the Operating Agreement required TOL to report on safety to TFL.

17. I am however going to identify some features as examples of the approach of TOL in particular and how opportunities were missed and failures amplified in terms of safety.

18. A Route Hazard Assessment was done in 2005; it was incomplete anyway, with possible consequences of some hazards omitted, but it did not include high speed derailment as a hazard at all. No risk assessment at all was done, and it is common ground that a hazard assessment is only a precursor to a risk assessment.

19. It was noted in the minutes of a TOL Safety Committee meeting on 3 June 2008 that "a high number of lights in the Sandilands Tunnel" were not working. There was a request that "the lighting be restored to its original condition" and "it was agreed by those present that the current lighting levels should be improved, and that any further deterioration could necessitate some form of additional operational control of movements in the tunnel". A joint group called the "Mods Panel" (meaning modification) considered lighting at three different meetings in 2008, obtained quotations, discussed lighting the tunnel to Network Rail Standards and these were "under consideration for inclusion in the 2008-9 budget". TCL, the predecessor to TFL, surprisingly stated that the original lighting "was probably excessive", and Mr Snowdon cautioned against changes from the original design. In August 2008 the minutes stated
"Tunnel Lighting at Sandilands
* Lighting is weak
* Official supposed to be in TCL 2008/09 budget"
A note was included that two individuals were "to meet and discuss issue in greater detail".

20. Again, nothing was done.

21. The Management Safety Review Meetings that were held from 2014 onwards show an unacceptably complacent approach to safety generally. The minutes of 24 November 2014 stated that route hazard assessments "hadn't been reviewed for a while". Given the most recent one available had not been reviewed since 2006, this is a considerable understatement. At the next meeting on 14 January 2015 one of the attendees is minuted as stating he "didn't think anything major needed to be changed." It was agreed that the same person would "revise and republish the document" (although this was not done) and another attendee suggested "going back to having a leaflet with key hazards on it for drivers". It was also minuted that such a step should be "in addition to the Route Risk Assessment" (which even by then had not been done, and was never done prior to the disaster).

22. At the next meeting on 4 March 2015 it is stated that this was "still in hand"; this means had not been done. This was repeated at a meeting on 30 March 2015, this time with the additional word "ongoing"; again, this must mean it had still not been done. On 20 April 2015 the following was changed and added, that in respect of going back to the leaflet for drivers identifying key hazards, "that should be addition to the Route <u>Hazard Assessment</u>" where before in 2014 that sentence had read "that should be addition to the Route <u>Risk Assessment</u>" (my emphasis). So the Route Risk Assessment that was stated as required in the earlier minute, and minuted as such, was changed so that it read Route Hazard Assessment – of which was already available, but from many

years before. There has been no explanation of this significant change was made to what was required. As the prosecution submitted:
“There is no indication on the minutes of how this backdated change came to be made. It is to be inferred that the committee appreciated the significance of the change that it was making.”
I accept that inference.

23. This saga, which amounts to the story of almost endless recitation in successive meeting minutes of steps being taken such as videoing the route, the work not being completed, updating the videos, and carrying the item forward to the next meeting, reads as a sorry tale of lack of meaningful progress, with the entry being ultimately marked “closed” without any risk assessment ever being done. Additionally, the most recent Route Hazard Assessment available as at the date of the disaster remained that from 2006.

24. Additionally, the minutes of the TOL Safety Committee from 2014 show that the item from 2013 relating to review of current risk assessments went on into 2015, and then seems to have fallen off the agenda entirely. The Head of Safety at TOL thought that it was not for TOL to identify any infrastructure of design improvements because these were not in the control of TOL, and they should not identify a need to do something and not be able to follow through on it.

25. This is because TFL was responsible for infrastructure so TFL was responsible for implementing changes. But this approach by the Head of Safety at TOL shows an unacceptable attitude to life and limb, and also is contrary to the Operating Agreement between TOL and TFL which specifically requires TOL to report on safety to TFL.

26. A Derailment Risk Assessment was done in August 2016 but this remained a generic document, did not identify risk of fatalities, and imposed no additional control measures to deal with this. Because of the way that multiple fatalities were ignored as a potential consequence within this document, this meant that the score for risk categorisation did not result in one for a Category I risk, which means “intolerable” and requires measures to be taken, but only a lower category, Category II, which is classified as “tolerable”.

27. One specific matter relied upon by the defendants must be specifically addressed. This is that the report into the disaster by Rail Accident Investigation Board (“RAIB”) should be an important part of the exercise to determine culpability. I reject that for two reasons. Firstly, the RAIB report itself expressly recites that it does not do this, and that is not the purpose of the report. Secondly, the trial of Mr Dorris heard a great deal of evidence from a large number of experts who did not give evidence to RAIB. As the trial judge, I am in a far better position, having conducted the trial and having seen and heard the witnesses give their evidence, than those who prepared the RAIB report. I have some regard to the contents of the report but take everything into account in assessing culpability, particularly the evidence at the trial.

28. I now turn to the warning email in respect of the near miss of 31 October 2016. I shall quote only part of it, but it was sent by a concerned passenger promptly after the incident on the day itself. She wrote “in regards of an incident which occurred this morning that nearly caused me my life” and explained that it was between Lloyds Park

and Sandilands, in other words, exactly the same place and in the same direction as the disaster 9 days later. She said that the driver "missed the bend or he was going too fast". She said she was "pitched to the corner of the tram and the man sitting on the other side came over on my side and pinned me to the corner of the tram" causing her to hit her head against the edge of the tram, injuring her shoulder and spraining her index finger. She "had never experienced such an incident before" and was now scared of using the tram. She described the incident as "unacceptable" and asked for an urgent reply. She submitted this to TFL, who promptly passed it to TOL. The answer from TOL to the passenger was wholly unsatisfactory, and merely sought more details. No meaningful investigation took place in the immediate aftermath, even though drivers were supposed to self-report such incidents and this driver (a different one to Mr Dorris) did not do so. This may have been because he was scared of disciplinary proceedings, as other drivers were. Had TOL approached this serious incident in a responsible way and treated it with the seriousness it merited, at the very least an emergency notification could have been put in the control room that all drivers have to read before going out on the network, warning of a high speed incident at the Sandilands curve and the effect it had on passengers. I consider this to be a significant aggravating factor in terms of culpability.

29. TOL was responsible for managing the drivers, and had a system where they were expected to self-report incidents. Many were reluctant to do so due to the adverse consequences, including disciplinary proceedings, that sometimes followed if they did. The system of self-reporting was not a safe one, and the regulator had suggested some time before the disaster that it be changed. However, it was not. I do not accept that either TFL or TOL ought to be criticised for a failure to have adopted technology in 2016 that was not in widespread use generally in the industry, but such technology was not required to prevent such a disaster. Sensible practical steps such as increased signage, improved visual cues and proper lighting within the tunnel could all have helped prevent it.

30. I turn therefore to the sentencing exercise itself. The relevant victim surcharges will be levied in the case of both defendants in the sum of £170.

31. I consider and apply the Sentencing Council's Definitive Guideline for Health & Safety Offences (and other offences) (the 'Guidelines'), and the detailed steps which a court sentencing for such offences must undertake. This is mechanistic because it must follow the approach set down in the Guidelines. I shall deal with each defendant separately when I come to the later steps and their financial situation and the fines, but there are some findings which apply to them both.

32. Step 1 requires that I first assess culpability. The prosecution submit that the level of culpability of both defendants is properly to be regarded as 'high'. Each of the defendants sought to persuade me that their culpability ought to be lower than that.

33. TFL contended that its culpability was medium, because although it accepts it fell short of the standards required, it did not fall far short. TOL also contend for medium culpability, and argues that its failures to appreciate the risk of high speed derailment were shared by the entire tram industry. I do not consider that this minimises TOL's culpability, even if I were to be persuaded that this is an accurate submission, which I am not. It ignores that there were 6 separate locations on the Manchester network

where additional controls were imposed at hazardous locations, which suggests that the submission is misplaced. But regardless of that, the breaches existed for many years – in TFL's case eight years, and in TOL's case, even longer than that, namely 16 years.

34. High culpability is, expressly stated in the Guidelines, to be determined where "the offender fell far short of the appropriate standard, by…..allowing breaches to subsist over a long period of time". That is plainly the case here, and I find the culpability of both defendants to be high.

35. Submissions that the court should proceed on the basis that the defendants' responsibility is anywhere other than high culpability are misconceived.

36. As to harm, it is agreed that, in terms of "seriousness of harm risked", this is a Level A case given that death and serious injury were risked by the offence.

37. There is, however, an issue as to the likelihood of that harm since, whilst the prosecution say that this is a 'high' likelihood case, the defendants' position is that it is a 'low' likelihood case.

38. I disagree with the defendants on this too, and find this to be a 'high' likelihood case. This was, in my judgment, undoubtedly an accident waiting to happen, quite literally. The fact that so many years passed without such a disaster does not mean that the risk of harm was not a high likelihood; it just means that the combination of circumstances had not occurred prior to November 2016. This is essentially a fact-specific evaluation which is ultimately a matter for the court. TOL in particular sought to deploy the law of probabilities to demonstrate that so many journeys had taken place over so many years without an incident, to justify a conclusion that it had a low likelihood of happening.

39. Other cases where other defendants could point to systems which were in place over a period of time and say that those systems had not previously failed do not really assist, as such a finding is so case and fact-specific. I have taken account what is said in the Court of Appeal authorities deployed by the two defendants, but in this case, on these facts, and with the benefit of the evidence that I have heard over a number of weeks in the trial, I conclude that there was a high likelihood of harm. This was not a combination of freak circumstances that could not have been predicted, or that was unlikely to occur. A driver becoming disorientated, braking insufficiently and therefore going into the curve too fast leading to a derailment and overturning had, in my judgment, a high likelihood of occurring.

40. The offence by each defendant therefore comes within 'harm category 1' in the Guidelines. As they makes clear, I must also as part of Step 1 ask two further questions: first, whether the offence exposed a number of workers or members of the public to risk and, secondly, whether the offence was a significant cause of actual harm?

41. There can be no sensible issue about the answers to each of these questions. A very large number of people were exposed to the harm risked in relation to these offences, namely everyone who used that route on the tram network. As to the second, the

offences were a significant cause of actual harm given the occurrence of the Croydon tram disaster and its widespread impact on so many people, both injured, seriously injured, and seven fatalities. I give "significant cause" the meaning that it has in the Guidelines.

42. In view of the fact that I consider that these offences are within 'harm category 1', this is not a case in which it would be possible to move up a harm category, as that is the highest category already. It is, nonetheless, both open to the court, and indeed in this case necessary, to move up within the range. I consider that this is required in this case, in particular given the nature and scale both of the offending and the number of people who were exposed to the risk of harm.

43. I turn therefore to Step 2. At this point, I shall deal with each defendant separately. It is agreed that TFL is to be treated as a 'very large' organisation. Its turnover is measured in billions of pounds, and very considerably above the upper limit of the turnover identified in the Guideline as being the threshold applicable to a 'large' organisation.

44. There is no specified category range for a "very large", as opposed to a "large" organisation. For a large organisation, the threshold for turnover is £50 million and the appropriate level of fine within the 'large' category range would be in a range of between £1.5 million and £6 million (with a starting point of £2.4 million). The Guidelines state 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."
That is the case here. It is necessary to move outside the range very much higher than that for a large organisation, given the size of TFL's turnover. Its turnover for the year 2022/2023 was £9.3 billion, which is many times the threshold of £50 million, but it would be wrong to multiply the figures in the range by that ratio. I must however move outside the range, whilst also bearing in mind that any fine that I impose will be paid, essentially, out of public money.

45. Before leaving Step 2, the Court must also consider factors increasing seriousness and factors reflecting mitigation.

46. As to factors increasing seriousness/aggravating features, I have already considered the length of time over which these failures subsisted to be a factor in assessing culpability, and I must avoid double counting. I consider that the failure by TFL to follow up with TOL on the warning email about the incident on 31 October 2016 that was (in the first instance) sent to TFL to be an aggravating feature. The defect with the speedometer on tram 2551 is also a factor that increases the seriousness of TFL's offending, as TFL was responsible for maintenance of the trams.

47. As to factors reducing seriousness or reflecting mitigation, TFL did try to be careful about safety and I accept that from 2008, when it acquired its interest in the network, it worked far more co-operatively and constructively with TOL than its predecessor had. It has no previous convictions and has a good record. There were effective procedures in place for other aspects of risk, and changes were made to the infrastructure within the tunnel before operations recommenced after the disaster.

However, balanced against that must be the fact that the significant and longstanding lighting defects were not properly addressed until later in 2017 when Mr Hale came on board, who gave evidence at the trial concerning the state of the lighting when he started. I accept that there was a high level of co-operation by TFL with the investigation, but that is to be expected given the circumstances and the fact that TFL would not, readily, be able to justify doing anything other than fully co-operate after such a disaster. It has accepted responsibility, and I accept it has provided support to those affected.

48. The top of the category range for a large company is £6 million. I must move outside that to reflect that TFL is a very large organisation with very considerable turnover, and also for the reasons explained at [42] above. Taking those factors into account, I consider that the movement upwards must be to a figure very considerably above the top of the range for a large company, and I move to a figure of £15 million.

49. Step 3 requires consideration of the proportionality of the proposed fine to the overall means of TFL. I have a large amount of financial information available, but the short point is that TFL has a substantial deficit and was kept afloat during the Covid pandemic, essentially, only by Government assistance of £6 billion and is dependent upon continuing substantial support. I do not consider the overall financial position of London Trams, which is not a defendant, to be directly relevant but I take account of it as background.

50. The purpose of a fine is to meet in a fair and proportionate way the objectives of punishment, deterrence and removal of gain. There is no gain to remove. Here, TFL submit that deterrence is not required in its case because the dreadful event and its consequences act as a deterrent for a public organisation such as TFL. However, deterrence applies to all other organisations, not only the offender. The requirement for punishment is centrally engaged, and a substantial fine does also reflect the seriousness of the offending, and serve as a deterrent to others. TFL have invited me to make a substantial reduction at Step 3 for reasons associated with its financial position. It explains in its witness evidence how dependent it is upon taxpayer support. It is indeed dependent upon such support but I decline to make such a reduction, and I do not consider that one is justified. So many millions of people depend upon TFL to conduct its operations safely, that notwithstanding its financial position and support by public funding, a substantial fine is required and I consider it would be wrong to reduce it because TFL's sizeable financial profile was hit so badly by the Covid pandemic.

51. I must also consider a reduction at Step 4, which is to consider other factors that warrant adjustment of the fine. TFL seek to persuade me that payment of the fine will reduce the amount of funds available to it that might otherwise be invested for the travelling public, including safety improvements. I decline to reduce the fine at this stage either. In my judgment, the travelling public will benefit in the long run, perhaps not in a direct financial sense, from a significant fine being imposed upon the organisation partly responsible for the dreadful Croydon tram disaster. There has to be a point at which the severity of that event translates into a significant fine, and I decline to reduce that fine because TFL has other calls on its funds and/or because it requires public support.

52. Step 5 does not apply. Step 6 I deal with collectively below after I have considered the fine I am going to impose upon TOL. At this stage and prior to Step 6 the fine against TFL is £15 million.

53. I turn now to Step 2 for TOL. It is agreed that TOL is to be treated as a 'medium organisation' given its turnover is in the bracket between £10 and £50 million. For a medium organisation, the appropriate level of fine within harm category 1 is in the range of between £600,000 and £2.5 million (with a starting point of £950,000).

54. Before leaving Step 2, the Court must also consider factors increasing seriousness and factors reflecting mitigation.

55. As to factors increasing seriousness/aggravating features, I have already considered the length of time over which these failures subsisted to be a factor in assessing culpability, and I must avoid double counting. There are more aggravating features with TOL than with TFL. TOL were the recipients of the warnings by Mr Snowdon, important matters which its submissions in mitigation suggest, even now, are not properly appreciated at TOL. The meeting minutes in my judgment demonstrate many rounds of meetings where lip service was paid to safety, such as where references to risk assessments (which were undoubtedly required for Route 3 and this curve) were specifically identified as required in the minutes, yet that term being replaced in later meeting minutes with different terms such as route hazard assessments. The route hazard assessment was 10 years old and never properly updated. TOL seek to downplay warnings of the type delivered by Mr Snowdon, who was described by TOL in mitigation as having "controversial views" and being an "outlier". I reject those submissions.

56. TOL was responsible for managing the drivers, and for a system whereby a driver had to self-report, a system that did not operate well and which the regulator suggested be changed so the culture could be improved. So many of the controls were dependent upon the driver, a system that would simply exacerbate the effect of any human error. I also consider that the failure by TOL to act in any meaningful way on the warning email about the incident on 31 October 2016 which it received promptly from TFL to be a significant aggravating feature. That email explained what had occurred, with a tram taking the very same curve at high speed such that injury was caused and the writer of the email feared for her life. It should have prompted a proper, timely and serious investigation and an immediate warning to all the drivers, placed on the noticeboard for such purposes in the control room. TOL sought to portray its reaction to the warning email of 31 October 2016 as a reasonable one. Loop data would have been available and could have been used to work out what had happened, as well as other sensible steps to obtain more information. I reject the submission that TOL responded to that important warning adequately. The warning was largely ignored.

57. As to factors reducing seriousness or reflecting mitigation, TOL did have committees and structures dealing with safety and I accept that it has no previous convictions and has a good record. There were effective procedures in place for other aspects of risk and an external consultant, QSS, was used to advise it on such matters. I accept that it co-operated with the investigation, but as with TFL that is to be expected given the circumstances. It would be difficult for any organisation to justify doing anything

other than fully co-operate after such a disaster. It has accepted responsibility, and I accept it has provided support to those affected.

58. Taking all these matters into account, a significant move above the range indicated in the Guidelines is justified, and I conclude at stage 2 of the sentencing process that an appropriate level of fine for TOL in respect of this offence would be £6 million.

59. I go on, then, at step 3, to consider whether the proposed fine is proportionate to TOL's means. I have studied the financial information and I consider that it is. I must also consider step 4. TOL has not paid a dividend and submits that it has not enjoyed any quantifiable economic benefit from the offending, which I accept. As with TFL, although considering the matter separately as I must for TOL, I decline to make any adjustment of the fine at this step.

60. Step 5 does not arise in this case.

61. This brings me to Step 6 and credit for the pleas of guilty in the case of both defendants. There is no issue that each defendant is entitled to the full discount available which is a reduction of one third, given the fact that guilty pleas were entered at the earliest opportunity. This discount is provided to all defendants if they plead guilty at such a stage of proceedings.

62. After that credit is applied, the fines I impose on each defendant are reduced by one third from the level they would have been. This means that I impose a fine of £10 million upon TFL, and one of £4 million upon TOL. This disparity between the fines arises solely as a function of the Guidelines in operation when one defendant has a far lower turnover than the other.

63. I am going to end these remarks by paying tribute to all those affected by the Croydon tram disaster. By this I mean all the passengers, the victims, those who attended at the scene to rescue people from the wreckage, and the friends and particularly the family members of the seven passengers who were killed. Some have attended court every single day, over many weeks. I wish to acknowledge this publicly and record that they have, without exception, conducted themselves with considerable dignity in the most difficult and distressing circumstances.

Fraser J 27 July 2023