JUDICIARY OF
ENGLAND AND WALES

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York College

Leeds Crown Court

14th February 2014

Sentencing Remarks of Coulson J

1. INTRODUCTION

1. On 17 September, 2012, Lydia Bishop, who was just 3, died on her first day at the nursery run by York College. She was found on the slide with her neck in a loop of rope, the loop being part of a longer piece of rope attached to and dangling down the slide. The evidence was that, unsupervised, she had gained access to the slide, which was in the furthest corner of the playground, bypassing the ineffective barrier designed to indicate that this area was out of bounds, and caught her neck in the loop as she went down the slide. Because no-one had seen her, she lay for a period of 20 minutes with the loop around her neck and her body positioned, feet-first, down the slide, before anyone realised she was missing. By the time that happened, she was dead.

2. Proceedings were brought against Ms Sophee Redhead, the Early Years Practitioner supervising Lydia that afternoon, and against York College. The charges against Ms Redhead, for gross negligence manslaughter and, in the alternative, for breaches of Health and Safety of Work Act 1974, were unanimously rejected by the jury in their verdict on 6 February 2014. At the same time, York College were unanimously convicted of a breach of the Health and Safety at Work Act 1974.

3. In sentencing York College, I have reminded myself of certain sections of the Criminal Justice Act 2003 ("the 2003 Act"), and the particular principles applicable to the sentencing of a company for an offence against Health and Safety legislation. The relevant principles

were recently summarised by the Lord Chief Justice in ***R v Sellafield Limited and Network Rail Infrastructure Limited*** [2014] EWCA Crim 49. In particular, I note:

(a) In considering the seriousness of the offence the court must have regard to the culpability of the offender and the harm caused or which might reasonably be caused (section 143 of the Criminal Justice Act 2003);

(b) A fine must have regard not only to the purposes of sentencing and the seriousness of the offence but must also take into account the matters set out in section 164 of the 2003 Act (which include the financial circumstances of the individual or company, which can either increase or reduce the amount of the fine).

4. I have also had regard to the Definitive Guideline of the Sentencing Guidelines Council, *Corporate Manslaughter and Health and Safety Offences Causing Death* published in 2010. Section B, entitled 'Factors Likely to Affect Seriousness', contains the following important passage:

> "5. This guidelines applies only to corporate manslaughter and to those health and safety offences where the offences shown to have been a significant cause of the death. By definition, the harm involved is very serious.
> 6. Beyond that, the possible range of factors affecting the seriousness of the offence will be very wide indeed. Seriousness should ordinarily be assessed **first** by asking:
> **(a) How foreseeable was serious injury?**
> The more foreseeable it was, the graver usually will be the offence.
> **(b) How far short of the applicable standard did the defendant fall?**
> **(c) How common is this kind of breach in this organisation?**
> How widespread was the non-compliance? Was it isolated in extent or indicative of a systematic departure from good practice across the defendant's operations?
> **(d) How far up the organisation does the breach go?**
> Usually the higher up the responsibility for the breach, the more serious the offence."

Paragraph B7 lists various possible aggravating factors, which include a failure to heed warnings or advice, and injury to vulnerable persons. Paragraph B8 identifies various possible mitigating factors, including a high level of co-operation with the investigation, a good health and safety record and a responsible attitude to health and safety.

5. Section C is concerned with the necessary financial information that the organisation must put forward and warns that a fixed correlation between the fine and either turnover or profit is not appropriate. Paragraph C/19 identifies a whole serious of factors the court

should consider when assessing the financial consequences of a fine, including the effect on what is called 'the employment of the innocent' and the effect on shareholders, and directors and the provision of services to the public. Paragraph C/19(viii) requires the court to consider whether the fine will have the effect of putting the defendant out of business.

6. Section D is concerned with the level of fines. Paragraph 25 provides:

> "The range of seriousness involved in health and safety offences is greater than for corporate manslaughter. However, where the offence is shown to have caused death, the appropriate fine will seldom be less than £100,000 and may be measured in hundreds of thousands of pounds or more."

Section I of the guideline summarises the proper approach to sentence.

7. My attention has also been drawn to a number of decisions which pre-date the guideline, including ***R v Howe*** [1999] 2 Cr App R(S) 37 and ***R v Yorkshire Sheeting and Insulation Ltd*** [2003] EWCA Crim 458, and two decisions of the Court of Appeal (Criminal Division) which post-date the guideline, namely ***R v Merlin Attractions Operations Ltd*** [2012] EWCA Crim 2670 and ***R v D Roche Ltd*** [2013] EWCA Crim 993. Both of these latter cases involved fatal breaches of the 1974 Act. In the former case, the fine of £350,015 was upheld by the Court of Appeal; in the latter, on a guilty plea following the death of an 80 year old woman, the fine was reduced on appeal to £70,000. But I also remind myself that, in paragraph 7 of his judgment in ***Sellafield***, the Lord Chief Justice noted that "the size of the penalty will depend on the facts of each case."

2. CONTEXT

8. Nothing that I say in the remainder of these sentencing remarks can provide comfort or recompense for Lydia's death; a child is priceless, so the loss of a child is an irredeemable loss. I have read the victim impact of Rebecca Dick, Lydia's mother, and it speaks eloquently of her loss and the breach of trust for which she blames the College. The fixing of an appropriate fine in a case like this is not concerned at all with putting a value on Lydia's life. But I would, at the outset, like to pay tribute to Lydia's family who sat in the public gallery throughout this trial, and behaved at all times with dignity and restraint. It has been a shattering experience for them, and I would like to pass on the Court's admiration for their courage and its best wishes for the future.

9. Equally, nothing I say is intended to diminish York College's hard-won reputation as an outstanding college of further education which makes an extremely important and valuable contribution to the life of the city. The failures that occurred here (which I am sure will never happen again) should not be allowed to obscure the obvious benefits that the College provides to its students and the wider community.

3. THE PARTICULAR FAILURES

10. The first step is to set out the particular failures on the part of York College which caused Lydia's death. For the reasons set out below, I consider that York College were guilty of two serious failings, one specific and one systemic. Those failings were the more tragic because they took place against a backdrop of the generally careful and thoughtful approach to health and safety matters at the College, a matter to which I shall later return.

11. The specific failure concerned access to the slide. The playground around the nursery was an inverted L shape, with most of the equipment in the area in front of the three rooms that made up the nursery building. But the playground also extended down at right angles from the main area, the narrow down-stroke of the inverted L, which comprised little more than a path leading to a slide right at the end of the playground.

12. The slide was placed on a mound and there were steps up the mound to the platform from which the children could then use the slide to get back down to ground level. The CCTV footage from 17 September 2012, and the evidence of some of the supervisors at the nursery, made plain that the slide was probably the most popular feature of the playground.

13. However, its location caused a problem of supervision. The slide was most popular with the Investigators (children from 2 to 3) and Buccaneers (children from 3 to 5). Neither of their rooms in the nursery building itself overlooked the slide. Furthermore, because the slide was tucked right at the far end of the inverted L shaped space, it was not visible from the main part of the playground either.

14. The slide could be seen from the sandpit, which was in the angle of the inverted L, but even then the view was not perfect, there being plants and equipment between the sandpit and the slide. Anyone standing there would be some way from the slide itself. Moreover, from the sandpit, it was not possible to see the far side of either the slide or the mound on which it was based. In short, effective supervision of the slide could really only happen if there was a supervisor in the area of the mound itself.

15. There was a good deal of evidence to this effect. For example, Lindsay Harrison, one of the supervisors on duty that day, said that, when the slide area was opened up, she waited at the sandpit whilst the children went past on their way to the slide but then, when actually supervising the children at the slide, she sat on the planter close to the mound. That can be seen in the CCTV footage. She did not supervise the children playing on the slide from the area of the sandpit.

16. The difficulty created by the location of the slide, and the strains that it imposed on proper supervision, were evident before Lydia's death. Ms Redhead gave evidence that, at an earlier meeting, a member of staff had said that a fence and gate should be installed leading down to the slide area so that, when the slide was out of bounds (because, for example, there were insufficient supervisors in the playground) access could be prohibited. She said that this request was rejected by the nursery manager on the basis that it would disturb what was known as the 'free-flow' of the children's play. Indeed, during the trial, much was made of the 'free-flow' ethos which allowed children to go where they wanted and do what they wanted both inside and outside. However it was not explained how making one part of the playground out of bounds for a period could adversely affect the children.

17. Other reasons given during the trial for the absence of a fence and gate, such as that it might mean that children got left behind when the area was closed up, or that it might disturb the natural atmosphere and ambience of the playground, were, on analysis, unsustainable. In my view, there was no good reason for the failure to take up the suggestion of a fence and gate, particularly when the evidence was that, if it was required for health and safety purposes, funds would have been available for any such installation. I find that the decision not to install the fence and gate was not a financial decision, or one made to maximise profits; it was instead an inexplicable and unjustified error of judgment.

18. Instead of the fence and gate, the staff were obliged to use a wooden bench, and a plastic trolley which contained the sand toys, as a means of blocking access to the slide. Ms Redhead called this a makeshift barrier and I agree: it was a ramshackle affair which, as the CCTV footage showed, was easily capable of being circumvented by the children, who could and did step round it. The evidence was that this arrangement had been operating at the nursery for some time, possibly even years.

19. I consider that the attempts to argue that the barrier was some form of educational device, a visual signal or sign that the slide area was out of bounds, were entirely unpersuasive. If

the staff needed a part of the playground to be out of bounds for a period, because of the strain on their supervision resources, then they needed a proper mechanism to assist that supervision, which completely blocked access to the slide. The bench and sand trolley were no such thing: Lydia simply walked round the side of the sand trolley on her way to the slide that was supposed to be out of bounds, just as other children can be seen doing in the CCTV footage.

20. Not only were the bench and trolley an inadequate aid to supervision, because they did not prevent children from getting past the barrier, they potentially muddled the way in which supervision could be performed. Although it was said at the trial that the staff did not rely on them, the presence of the bench and trolley could easily lead a supervisor, who had taken his or her eye off the barrier momentarily, to assume that no children had got past it. If a child had got past it because a supervisor had taken their eye off the barrier, that child could get into the slide area and then remain invisible to the rest of the playground. Tragically, that is what happened to Lydia. She could not have got to the slide if the slide was closed off with a fence and gate.

21. The systemic failure related to the rope that was to strangle Lydia. It appears that a long length of rope, some 16 metres in length, was regularly attached to the slide to allow the children to pull themselves up the mound. The rope was relatively thick and easily formed coils. A number of the witnesses described it as climbing rope. The rope only has to be examined to see at once the potential danger it posed to small children.

22. York College made a feature of what they called 'challenging' play, and playing with ropes was one aspect of that. But York College was also rightly aware that the rope or ropes could cause serious harm to the children. Accordingly, as part of their health and safety regime, they produced two separate risk assessments which dealt with the use of the rope in the outside area. Those risk assessments expressly identified that the rope posed to the children the risk of strangulation. There were two particular control measures identified in the risk assessment to deal with that risk: putting the ropes out of reach of children when the ropes were not in use, and supervision.

23. Given that supervision was, of course, dependant on so many variables (including the bench and trolley arrangement, the ratio between staff and children, and what else was going on in the playground) the other principal control measure – putting the ropes away when they were not being used – had the merit of clarity and simplicity. That doubtless explained why

many of the witnesses at the trial confirmed that, if the rope had been put away after the last time it had been used under supervision, Lydia would not have died.

24. The evidence established beyond any doubt that this control measure was sometimes ignored. Instead, the rope was often treated by the nursery staff as being just one element of the equipment available to the children in the playground. So, as with the other equipment, once the rope had been taken out and brought to the slide area, it was often left out and only tidied away at the end of the day. Some witnesses (like Chloe Moses and Mathew Parkin) said that, as a matter of routine, the rope was put away at the end of the day, but not after each supervised play session; others, like Sophee Redhead, acknowledged that this happened but said that such a practice was occasional.

25. There was some evidence that the rope was not even put away at the end of the day (and certainly the rope that was present on Monday 17th September had been left out since the previous Friday). But that evidence was much less extensive and much less persuasive. It may well have happened, but only very occasionally. I do not sentence York College on the basis that the rope was regularly left out overnight. However, ultimately that does not seem to me to make very much difference. Because the rope was often left out all day, one of the critical control measures in the risk assessment, to put the rope away when it was not in use, was ignored. This had been happening, on and off, for some time; thus the condition at the slide on the afternoon of 17th September 2012 was not an isolated incident.

26. There was some evidence that some of the staff had not seen the risk assessments themselves, but they were posted up close to the equipment so it does not seem to me appropriate to criticise the College for failing to publicise the risk assessments. Moreover, every member of staff who gave evidence agreed that, regardless of whether or not they had seen the risk assessments, they knew that the rope should be put away when it was not being supervised. Much more serious was the complete absence of any evidence to show that the College had a system of checking/monitoring/ensuring that the control measures were being implemented.

27. I conclude on that evidence that no one at York College saw it as their responsibility to check, as a matter of regular routine, that any of the stated control measures were actually being implemented. Ms Jill Corrigan, who had prepared the risk assessments, said that that was not her job and was instead the responsibility of Ms Liz Radford, the nursery manager. Ms Radford denied that this was a matter for her, and said she only went to the nursery for

health and safety purposes if something was specifically brought to her attention. She hinted that such a task may have been the responsibility of Mr David Jackson, the Health and Safety Manager at the College. Mr Jackson did not give evidence, but from other evidence I concluded that the nursery was not very high up his list of priorities (it being somewhat removed from the College's core activities), and that he only visited the nursery for a specific purpose, such as a fire assessment or an inspection for an annual audit. There was no evidence that he undertook any routine or regular inspections to see if the control measures were being implemented.

28. Ultimately, in relation to the rope, this was a very important failing because it was not uncommon for the rope to be left out throughout the day, and then tidied away when the nursery closed at 6pm. That was contrary to the control measures in the College's own risk assessment. That situation should clearly not have been allowed to happen; it happened because there was no regular system of checking – no weekly or monthly inspections, no records, no box-ticking - to enforce the control measures.

29. Accordingly, I take the view that Lydia's death was the result of one specific failure, and one systemic failure. The specific failure was the failure to appreciate that a proper barrier was required to prevent children from getting to the slide area when there were insufficient numbers of staff properly to supervise that remote part of the playground, and by instead relying on the so-called visual sign provided by the bench and trolley which was a wholly ineffective barrier. The systemic failure was the failure to enforce control measures generally and, specifically, the failure to enforce the control measure that required that the rope to be put away after use.

4. CONCLUSIONS ON HARM, SERIOUSNESS AND CULPABILITY

30. Lydia Bishop died because the barrier to the slide was ineffective and because the ropes had not been put away after use. Therefore the harm arising from the two failings that I have identified could not have been more serious (B5 of Definitive Guideline).

31. In my view the seriousness of the offending, and therefore the culpability of the College, was high, although not very high because it did not extend to the very top of the management chain. It was high because the bench and trolley were obviously ineffective, and a sensible and cheap solution had been suggested but not implemented. The risk of children getting past the barrier and into an unsupervised area was therefore foreseen, let

alone foreseeable (Section 6(a) of the Definitive Guideline). The College fell a long way below an appropriate standard (Section 6(b) of the Definitive Guideline) because they failed to act on the sensible suggestion of a fence and gate, for reasons which were unjustified, and allowed a plainly inadequate measure to be used for so long. This specific failure extended to the Nursery Manager and the Health and Safety Manager but not higher up the management chain (Section 6(c) of the Definitive Guideline).

32. The seriousness of the offending in respect of the rope was also high. Putting away the rope when it was not in use was the College's stated solution to the risk posed by the rope. The College's own risk assessment said that there was a risk of strangulation if that control measure was not implemented: thus the risk of serious injury, even death, by strangulation, was again foreseen by the College, let alone foreseeable (Section 6(a) of the Definitive Guideline). The College fell a long way below an appropriate standard (Section 6(b) of the Definitive Guideline) because they failed to put in place any mechanism whereby their own control measures were checked, monitored or enforced. That was a systemic failure that went back as far as the risk assessments themselves; the evidence suggests that there was never any system of checking/monitoring/enforcement. That failure was principally that of the Health and Safety Manager; even though it was systemic, it is difficult on the evidence to say that responsibility for it should also extend to the member of the Senior Management Team responsible for health and safety matters.

5. AGGRAVATING AND MITIGATING FACTORS

5.1 Aggravating Factors

33. In addition to the matters noted above, and by reference to Section B7 of the Definitive Guideline, there were the following aggravating factors:

    (a) The risks created by the makeshift barrier were known because the matter had been raised at a staff meeting. The evidence was that the warning was deliberately ignored (Section B7(b) of the Definitive Guideline).

    (b) Other children, not just Lydia, were exposed to the risk of the rope on the slide. They were all very young and so acutely vulnerable (Section B7(e) of the Definitive Guideline).

5.2 Mitigating Factors

34. In my view, there are four mitigating factors which seem to me to be significant. In brief:

(a) I consider that York College generally took health and safety matters seriously. The risk assessments were suitable for their purpose and, because they were posted around the nursery, properly drawn to the attention of the staff. The basic rules were all well-known to the supervisors in the nursery (Section 8(e) of the Definitive Guideline);

(b) York College have no previous convictions or warnings in respect of the health and safety at the nursery. On the contrary, any third party who has inspected the nursery prior to the accident, such as Ofsted and York Council, was extremely complimentary about the way in which it was run, including in respect of safety issues. The report produced by RSM Tenon in October 2011 dealing with the College's Health and Safety Framework, was also couched in extremely favourable terms (Section 8(d) of the Definitive Guideline);

(c) The College reacted to Lydia's death by closing the nursery and it has never been re-opened. Moreover they have taken a number of steps to ensure that this sort of accident could not happen again;

(d) York College derives much of its income from public funds, which is a factor that needs to be considered for the purposes of the amount of any fine (Section C of the Definitive Guideline). I deal with that matter in greater detail below.

35. I would wish to expand what I say about the mitigating factors by dealing expressly with three submissions put forward by the College by way of mitigation. First, whilst I accept that in many ways the College co-operated fully with the police inquiry, there were some omissions. Thus the evidence before the jury was that, although Ms Redhead gave a very full statement to the police on the day after Lydia's death, a number of the College staff did not answer the questions asked by the police during the investigation. The College Principal answered 'no comment' to the questions put, and although she put in a lengthy pre-prepared statement, that statement dealt with barely any relevant matters. The relevant member of the Senior Management Team responsible for health and safety, Ms Lawrence-Crockford, also answered no comment, even in relation to basic matters of fact. That was their right, of course, but it cannot fairly be described as 'full co-operation'.

36. The second issue, the College's generally careful attitude to health and safety matters, is something to which I have already referred. I think that Mr Lynagh QC and Mr Antrobus are right to say that, on the evidence, the College took health and safety matters seriously, and

had a good structure in place to deal with them. I consider that the failures in respect of the nursery were not typical of the College's overall approach to health and safety, and can, to that extent, be described as out of character (albeit that they were not the result of an isolated incident and were reasonably foreseeable). That raises a question as to some of the reporting of this case which, encouraged by the police, has wrongly hinted at a cavalier attitude within the College towards health and safety issues. I deal with one aspect of that at the end of these sentencing remarks.

37. Thirdly, I accept the College's submission that they were devastated by what happened on 17 September; they have reacted responsibly to Lydia's death; and they have put in place appropriate measures to review and improve their health and safety practices. The statement of Mr John Short, the Chairman of the Board of Governors is illuminating on this, and many other matters. He sets out in detail the degree of upset and remorse caused throughout York College by Lydia's death. He also records that the likely costs to the College of closing the nursery may exceed £400,000.

38. As to the extent to which lessons have been learned, it is worth setting out paragraphs 28 and 29 of his statement in full:

> "28. That decision [to close the nursery] was not, however, seen as representing the end of the matter so far as the College was concerned. It was appreciated by all that the safety management system required careful review in light of an incident such as this, irrespective of the closure of the nursery, because the College still opens its doors to thousands of students each day and must demonstrate that it is safe to do so. With that in mind, I am aware that the following measures have been taken at York College as part of the process over the years of continuous review of health and safety procedures/systems:
>
> (a) An external health and safety expert (recommended to the College by the HSE) carried out an immediate health and safety inspection of the College after the incident involving Lydia which was followed by a full British Safety Council audit the following year;
>
> (b) A small project group was established, chaired by the Principal, to oversee the action plan for what was expected (at the time) to be the re-opening of the nursery (including refresher training of staff etc.) and which thereafter

focused on (and still does meet to focus on) taking forward actions relating to health and safety in the College;

(c) Risk assessments have been reviewed throughout the College and mandatory refresher training instituted for all staff, together with some Governors, in relation to health and safety aspects of College life;

(d) Whilst daily checks were in place, they are now specifically documented for all College workshops and other areas considered to be higher in risk;

(e) Compliance checks continue regarding manager inspections, audits and student and staff health and safety inductions;

(f) Additional regular review of risk assessments, induction procedures and monitoring procedures;

(g) Unannounced spot checks by the health and safety team across all sites to check compliance with control measures. Actions taken where appropriate.

29. The safety management system was then subjected to an audit by the British Safety Council in June 2013 and was awarded 5-star status ('Excellent'). I understand that the BSC report is included within the mitigation bundle. An action plan relating to this audit is being followed through and progress reported to senior managers and governors."

6. THE RELEVANT FINANCIAL AND OTHER INFORMATION

39. I have been provided with a good deal of financial information relevant to the fixing of the fine. In summary, the evidence is that:

(a) York College is a registered charity. The majority of its income (83%) is from the public purse. It has no shareholders and distributes no profit. Any surplus is put back into the College

(b) Although it has Reserves of about £30 million, these are largely fixed and are not available for future spending. Nett Current Assets are just over £9 million but the College has financial obligations over the next three years which will account for the vast majority of that amount.

(c) York College has always specialised in Construction Industry training, and has a major capital project ongoing for a new Construction Centre which will cost approximately £6 million.

(d) The accounts for the year ending 31.7.13 show a deficit of £276,000, whilst the cash from operating activities has reduced from £2.3 million in July 2012 to £570,000 for the year ending July 2013. Much of this reduction is explained by the decision to close the nursery.

(e) York College anticipates a surplus for the year ending 31.7.14 in the region of £400,000.

40. It is conceded that the financial information shows that it would be able to pay a penalty of up to £500,000, although it is said that in all the circumstances of this case, the fine should be fixed at less than the £100,000 referred to in the Guideline. I deal with this submission in the next section of these Sentencing Remarks.

7. THE APPROPRIATE FINE

41. I consider that, in all the circumstances of the case, only a substantial fine is appropriate. I note that Paragraph D/25 of the Definitive Guideline suggests that a fine of less than £100,000 in any case where death has been caused will 'seldom' be appropriate.

42. I do not accept that this is an exceptional case which warrants a fine at a figure below £100,000. In one sense this kind of case is all too common: a first-class institution, with numerous outstanding qualities, failed to do two things which were reasonably practicable, in respect of one part of its operations, and a tragic death ensued.

43. The seriousness of the offence, and the College's culpability for it, both of which I consider to be high, and the aggravating factors noted above, would lead me to think in terms of a level perhaps three times the figure of £100,000 referred to in the Guideline. But the mitigating factors, including the College's funding position, the financial impact so far, and the lessons learned, would suggest a significant reduction from that sort of figure.

44. For all these reasons, therefore, I fix the fine in the sum of £175,000. It will be seen that such a level of fine is just over half that imposed in ***R v Merlin*** (where the defendant was a much bigger organisation but whose culpability was lower than that of the College), and a bit more than twice that in ***Roche***, where the defendant care home was a modest business and where the original fine of £150,000 would have led to the loss of 75 jobs. That factor,

which does not apply here, made that case exceptional. The defendant in that case was also given full credit for its guilty plea.

45. A fine of £175,000, when considered with the figure for costs, noted below, is also broadly in line with the figure in the similar Crown Court case of ***Epping Forest District Council v Casterbridge Care and Education Ltd and Another*** (July 2013) where the defendants were commercial organisations.

46. I have considered the consequences of a fine fixed at £175,000. It seems to me that a fine at that level can be paid; it will have no significantly detrimental effect on the College's future plans; and it is capable of being paid without risking job losses or a reduction in the services provided by the College.

8. COSTS

47. The Crown seeks its costs in the total sum of £45,453.94. No issue arises as to the College's liability to pay costs, and the figure seems to me to be relatively modest. I therefore allow that claim in full. It should be noted that this figure includes the costs of prosecuting Ms Redhead. It is, I think, in keeping with the spirit of Mr Short's statement that the College should pay those costs, even though of course the decision to charge her was nothing to do with the College. I consider that the College has generally been as supportive as they could be of Ms Redhead, although it was inevitable that at trial there would be marked differences between their respective defences.

9. 'A TICK-BOX EXERCISE'?

48. On the afternoon of 6 February, within minutes of the conviction of York College and the acquittal of Sophee Redhead the North Yorkshire Police, released a press statement in which, amongst other things, they said that the rope had been in place on the slide for about two months. Detective Inspector Costello was quoted as saying that "health and safety is more than just a tick-box exercise". The statement was widely reported.

49. Whilst statements of this kind can be made before the end of proceedings, provided they do not cause prejudice to the defendant, they are ill-advised, particularly where, as here, they are woefully inaccurate. On that basis, the statement could have been potentially prejudicial to York College, who are already unhappy at some of the reporting of this trial in

the media. At the very least, ordinary principles of justice require me to correct the statement publicly.

50. The statement that the rope had been in place for about two months is simply wrong. As I have made clear, the evidence did not support any such conclusion and I have not sentenced York College on that basis. In circumstances where the jury does not give reasons for its decision, it is an abuse of the criminal justice system for the police to provide their own, incorrect, reasons.

51. DCI Costello is also quite wrong to say that, in some way, York College's approach to health and safety was a matter of box-ticking. It was not, as anyone who had actually listened to the evidence in the trial would know. I have already explained at some length that the reasons for Lydia's death arose from one specific failing (not dealing with the particular problem of access to the slide) and one systemic failure (failing to enforce the implementation of control measures). Neither of those failings resulted from any alleged 'tick-box' exercise, or demonstrated an approach which put 'box-ticking' ahead of substantive matters.

52. More widely, I consider that DCI Costello's remarks are positively damaging. It is very easy for those who are not involved in the details of health and safety operations on a daily basis to criticise those who are for having a 'tick-box' mentality. It is a cheap and easy jibe. But in reality, in the workplace, or in the hospital or the school, having a system whereby something is inspected and then noted as satisfactory, with the result recorded on a form as a box ticked, can often be the best way of ensuring that a health and safety regime set out on paper is actually being complied with in practice.

53. One element of this case provides a good example of that. If the Health and Safety Manager at York College had undertaken a regular inspection regime at the nursery, with the risk assessment in front of him, seeing whether the control measures were actually being implemented, and ticking a box if they were, he would have been unable to tick the box that said that the ropes were being put away after use. Having been obliged to cross, not tick, the relevant box, he would then have ensured that everyone knew that the ropes were to be put away after use, and the accident might never have happened.

54. On that basis, you could make a strong case that, in relation to the rope, what went wrong here was not that the College had a tick-box mentality, but that it did not. In my view, crass generalisations of the kind made by DCI Costello simply serve to undermine proper and

efficient health and safety regimes up and down the country, and make this sort of tragedy more, rather than less, likely to happen.