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IN THE COURT OF APPEAL
CRIMINAL DIVISION

Royal Courts of Justice
The Strand
London
WC2A 2LL

Friday 8th February 2019

B e f o r e:

LORD JUSTICE IRWIN

MRS JUSTICE CUTTS DBE

and

HIS HONOUR JUDGE PAUL THOMAS QC
(Sitting as a Judge of the Court of Appeal Criminal Division)

R E G I N A

- v -

ST MICHAEL'S HOSPICE HASTINGS

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Mr T Green appeared on behalf of the Applicant

Mr S Mehta appeared on behalf of the Crown

J U D G M E N T
(Approved)

Friday 8th February 2019

LORD JUSTICE IRWIN: I shall ask Mrs Justice Cutts to give the judgment of the court.

MRS JUSTICE CUTTS:

1. This is a renewed application for leave to appeal against sentence following refusal by the single judge.

2. On 6th March 2018, at the plea and trial preparation hearing in the Crown Court at Lewes, the applicant, St Michael's Hospice Hastings, a registered charity, pleaded guilty to two offences of failure to take general fire precautions, contrary to Articles 8(1)(a) and 32(1)(a) of the Regulatory Reform (Fire Safety) Order 2005. The first count related to failure on 11th July 2015 to take such general fire precautions in respect of the hospice premises as would ensure, so far as reasonably practicable, the safety of any of its employees, which failure placed them at risk of death or serious injury in case of fire. The second count related to identical failings on the same date in relation to relevant persons who were not employees, and this plainly included patients resident in the hospice at that time.

3. On 28th March 2018, the applicant was sentenced to a total fine of £250,000, which comprised £80,000 on count 1 and £170,000 on count 2, consecutive. The applicant requested, and was granted, three years within which to pay the fine.

4. The sad facts leading to the prosecution of the applicant were these. At about 12.40am on 11th July 2015 a serious fire occurred at St Michael's Hospice in St Leonards on Sea. The fire was ignited on the male ward, situated on the ground floor of the premises, and spread relatively

quickly. It is not known precisely how the fire began, although it is thought that it may have been set deliberately by a male patient. There were nine staff on duty at the time and 25 residents within the building: nine on the ground floor and eight on each of the first and second floors. The patients had a range of mobility issues. Many were sedated to assist a good night's sleep.

5. During the fire the staff did all they could to evacuate residents, initially from the sub-compartment of origin and then from the whole of the ground floor. As the fire and smoke spread further around the building and started to affect the upper floors, a decision was taken to evacuate the whole premises. It is plain that the staff worked tirelessly, but they were unable alone to evacuate all residents. Some had to be rescued from the main fire compartment on the ground floor by fire fighters wearing breathing apparatus. They assisted staff to evacuate the remainder of the premises. It became clear that the staff had no adequate training in evacuating patients with a range of mobility difficulties. Beds were too wide to get through doors, and a lack of appropriate equipment hindered the evacuation of residents downstairs. Some were taken downstairs on the laps of staff. Others were carried in blankets, or in one case lifted down in a normal chair without safety restraints, causing that resident to fall out of the chair during the descent down the stairs. Locked exit doors could not be readily opened by staff who had to leave some patients in the smoke-filled premises. Holes within the ceiling, but concealed by the false ceiling, allowed smoke and heat to spread quickly to the upper floors.

6. Those residents worst affected by the fire (ten in all) were taken to hospital. Others were taken to a nearby residential home. Within 24 hours of the start of the fire, three residents had sadly died. Subsequent post-mortem examinations revealed that the fire was a causal factor in the deaths of two of them. We recognise that all of the patients are likely to have been seriously affected by what happened.

7. Impact statements from the families of those who sadly died were available to the judge and we, too, have read them. Mrs Moon's family described her as visibly traumatised and injured following the fire. She told them of her fear when the fire broke out, owing to her inability to move. The family of Mr Denness spoke of him being abandoned at the end of a corridor, as the door opening was too narrow to move the bed through. All spoke of feeling let down, having entrusted their loved ones to what they thought to be a place of safety, only to find that it was not.

8. The investigation consequent upon the fire revealed the following upon which the prosecution relied. In January 2014 the Fire Services wrote to every hospice in the country, highlighting nationwide concerns about risks to vulnerable residents with limited mobility in the event of fire. It highlighted the need for exit doors being easy to open and sufficient numbers of staff at night to ensure a safe evacuation. The applicant was, therefore, on notice of the need to ensure that this was the case.

9. On the night of the fire, exit doors in the hospice were locked or unusable. The main fire exit on the ground floor was locked and could not be opened by staff. A further exit was locked and was too narrow to allow evacuation as the beds could not fit through. Other doors were also locked.

10. Fire officers found holes in the ceiling and the walls. These were not immediately visible owing to the false ceilings, but were obvious once one looked beneath them. These and further holes allowing access for piping and electrical wires to all rooms were insufficiently filled in. This created a risk of fire and smoke spreading quickly throughout the building. Some of the doors were not fitted with smoke-seals. The holes had been identified as a risk in a Fire Hazard

Report written by a specialist fire consultant, Mr Scott Yorden, dated 10th March 2015, some months, therefore, before the fire, but the risk had not been acted upon. It appears that the hospice were seeking to obtain funds in order to act upon the Fire Hazard Report, but we pause to note that the hospice had reserve funds which could have been used for this purpose and then reimbursed through a fund-raising scheme.

11. The prosecution relied on the fact that there were insufficient numbers of staff on duty to evacuate all of the residents in the building. A Fire Report, dated 13th August 2014, written by an employee of the applicant, had recommended the purchasing and use of evacuation chairs as the best solution to what was then recognised to be the immediate problem of moving patients with mobility issues. The author identified this as only a partial solution to the hospice's evacuation plans and that another member of staff was working on a more detailed procedure, including the order in which to evacuate patients and what to do with them once evacuated. No such chairs had been bought or plan worked out.

12. The staff had never been trained in, nor carried out, any real evacuation. They had not before the fire considered how they would get patients down the stairs in the event of a fire. They did not have the right equipment so to do.

13. Doorstops were being used to keep doors open which should have been shut when the fire began. The risk assessment held by the applicant was inadequate and lacking in detail. It did not identify the failings already mentioned. There was defective fire zoning delineation and most of the breaches had persisted for some time.

14. The applicant's basis of plea emphasised that this was not a case where there was no fire risk assessment in place. In 2006, almost immediately after the Fire Safety Order came into force,

the hospice obtained a fire risk assessment. It acknowledged that at this time it only occupied the ground floor of the premises which were thus less complex than at the time of the fire. Thereafter, they relied upon a fire risk assessment prepared in 2013 by employees of the applicant who, with the benefit of hindsight, were insufficiently trained or experienced in fire safety to provide such an assessment. The applicant accepted that the fire-resistant construction of the premises was breached in various places and that this had been brought to their attention in March 2015. As we have already noted, plans were in place to install sprinklers in September 2015, which would have substantially mitigated the risk. It was accepted within the basis of plea that the general fire precautions for the whole premises were inadequate. There was a fire safety and evacuation plan in existence, but the applicant accepted that it fell short of all that was reasonably practicable to ensure a safe means of escape. This included an over-reliance on one staircase as the means of escape, with other doors not on the designated escape route locked, and inadequate evacuation equipment and training, albeit there had been some. The applicant maintains that the risk of arson by a patient could not have been reasonably foreseen.

15. There are no sentencing guidelines applicable to fire safety cases. With the agreement of the parties, the judge, in sentencing the applicant, followed the guidance of this court in *R v Sandhu* [2107] EWCA Crim 908 and assessed questions of culpability and harm by reference to the Sentencing Council Guideline for Health and Safety Offences. As the court observed in that case at [22], whilst they are not directly referable to fire cases "they do provide a useful check for considering whether a sentence arrived at … is either unduly lenient or manifestly excessive".

16. We underline that the health and safety guideline is a check only. Breach of Fire Order offences are not included within those guidelines – and deliberately so. This, in our view, can only be because the risks associated with fire are different.

17. In sentencing the applicant, the judge reminded herself that the purpose of so doing was not to mark the loss of lives subsequent to the fire, but to sentence the applicant for the breaches of the fire regulations. She recognised that the hospice is a key provider of palliative care and that there would be an inevitable impact on the provision of their services for the local community by reason of their conviction and sentence. She concluded that the applicant's level of culpability was high and that it fell far short of the appropriate standard. The responsibility of dealing with fire risks lay firmly with the hospice, who had failed to put into place obvious and recognised measures. They had failed to act on risks identified to them which they allowed to persist over a long period of time.

18. In relation to harm, the judge observed that in its guilty pleas the applicant accepted that its failures placed their employees and residents at risk of death or serious injury. She found that the cumulative effect of its deficiencies in the event of a fire resulted in a high likelihood of harm. She found that the offences were aggravated by the number of employees and residents who were at risk of serious harm – approximately 40 people in total – and by the fact that the applicant's breaches were a significant cause of actual harm. These factors warranted, in her view, an uplift in the starting point.

19. In mitigation the judge took into account the hospice's previous good character and its status as a charity. She recognised that it offered a much valued service within the community and was reliant on donations largely from the families of those it had cared for. She accepted that significant steps had been take after the fire to ensure that fire safety was given the priority it should always have had.

20. In reaching the appropriate level of fine, the judge treated the applicant as a small business

in terms of turnover. She reminded herself of the need for the level of the fine to reflect the extent to which the applicant fell below the required standard and that it must be sufficiently substantial to have a real economic impact which would bring home to management the need to comply with regulations. She observed that it was obvious that any fine for a charity such as a hospice will impact on their ability to use their resources to offer their current level of care. However, in her view, it would not be an acceptable message to such institutions that exceptional palliative care can dilute the requirements to have robust fire safety policies in place.

21. The judge reached a starting point in the sum of £425,000. She reduced this to £400,000 for the mitigation and reduced the figure by a further 30 per cent to reflect the applicant's charitable status. She afforded the applicant 25 per cent credit for its guilty pleas. This brought the sum to £210,000 for a single offence. As there were two offences relating to different groups of people, she came to a final figure of £250,000, which she apportioned between the counts in the way we have already indicated. She afforded the applicant three years within which to pay the fine.

22. In his submissions to this court on behalf of the applicant, Mr Green accepts that culpability in this case was high and that the deaths of two patients were an aggravating factor, as was the fact that other were exposed to risk. The applicant seeks leave to appeal against sentence on two grounds. First, Mr Green submits that the judge adopted too high a starting point because she wrongly assessed the likelihood of harm as high. He submits that the true likelihood of harm from breaches of the Fire Safety Order in this case was low because the risk of a fire at the hospice was low. It is submitted that the judge conflated the assessment of the likelihood of harm with the level of harm that might follow in the event of a fire. It is his submission that the applicant should have been sentenced on the basis of a medium likelihood, combined with level A harm, and such would have reduced the starting point.

23. Secondly, Mr Green submits that the judge gave insufficient weight to the applicant's mitigation, in particular to the fact that the applicant is a charity which must pay the fine from reserves made up of charitable donations from the public. Further mitigation could be found, he submits, in the lack of previous convictions, the good health and safety and fire safety record of the hospice, their co-operation with the Fire Services and the full remediation package.

24. With respect to Mr Green, in our view his submission that there is a low risk of a fire breaking out in a hospice misses the point. As was made clear by this court in *R v Butt* [2018] EWCA Crim 1617 (a decision after the sentence hearing in this case), in most prosecutions for a breach of the Fire Order, there will be no evidence of a special risk of a fire breaking out. But, nonetheless, the law imposes a high standard for precautions to guard against the risk of fire. This is because of the very serious consequences that can flow from fire and also because it is so unpredictable how and when it will start. Severe penalties for the offence do not depend on an enhanced likelihood of fire, although of course if there were such a risk, it would prove a serious aggravating factor.

25. The question for us in this case is not how the judge came to her starting point, but whether such could be said in all the circumstances of the case to be manifestly excessive.

26. In this case there were serious breaches of the Fire Safety Order. As the judge in her careful sentencing remarks observed, had there been a basic level of fire training incorporated into the routine of the hospice, the failures to take proper fire precautions would have been obvious and could have been rectified simply and at little cost. The applicant's failures in this regard placed extremely vulnerable people at significant risk. As the judge said, the applicant's deficiencies, some of which had been long-standing, were ruthlessly exposed when fire did break out in July 2015. Actual harm was caused to residents of the hospice.

27. We find ourselves unable to agree that in these circumstances the judge adopted too high a starting point. It was entirely appropriate to meet the justice of the case.

28. We are also unable to accept the submission that the judge failed to afford sufficient weigh to the applicant's mitigation. In our view, she adopted a flawless approach in this difficult sentencing exercise. She significantly reduced her starting point to reflect both the applicant's mitigation and its charitable status. Proper credit was given for the applicant's guilty pleas. She recognised the applicant's limited means and the way in which it was funded in affording a generous time within which to pay the fine.

29. We recognise that the hospice does important work. We recognise the dedication of its nursing and medical staff, who cannot be held responsible for what happened on 11th July 2015. We recognise the generosity of the public in making donations to enable the hospice to operate for the benefit of all. They cannot be held accountable in any way.

30. It is the management of the hospice who failed to comply with their duty and the breaches of that duty were serious and significant in a way, in our view, that had to be marked.

31. It follows that we are unpersuaded that the sentence in this case was manifestly excessive. It was just and proportionate.

32. We therefore refuse the application for leave to appeal against sentence.

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proceedings or part thereof.

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