Warwickshire County Council

Judgment and sentencing remarks

1. In the unusual circumstances of this case – circumstances which will become apparent as I speak – that which I am about to say will, I fear, be something of a cross between sentencing remarks and a full Judgment.

2. Before I say anything else, I propose to say a few words at the very outset of what will take, I fear, some little time. This was a tragic case involving the deaths of four fine men. I know that their relatives have taken a close interest in this case and I believe that some of them attended every day of the earlier trial as well as this hearing – even travelling to London for short directions hearings. I also wish it to be known that I have read the impact statements and I understand the anguish which is felt at the loss of the lives of young men; men who had their lives ahead of them; men who were following their calling either as retained firefighters or full timers; men who went into the fire compartment fearlessly in what, at the time, was perceived to be a routine piece of fire fighting. Nothing can bring them back; and nothing but time the healer can ameliorate the great senses of loss grief and bereavement suffered by those left behind. Nothing which I propose to say later should in any way detract from that. I have of course the most enormous sympathy. But I know that those family members who are here today will understand my task – to make findings, to assess blame, and to impose a fair and just penalty for the failings to which the Defendants have admitted or have been proved against them. I want it to be known that those sentiments should be taken as forming the constant backdrop to all my later remarks.

3. It is an unusual experience for a judge to sentence a corporate body. There is no defendant to look in the eye; and there is but one sentence available; a financial penalty. The Defendant has pleaded guilty to a single charge of failing to ensure so far as was reasonably practicable the health safety and welfare of its employees contrary to section 2 of the Health and Safety at Work Act. It pleaded guilty at the earliest possible moment and requires appropriate credit for that. However, it pleaded guilty upon a limited basis – a basis which the Crown was not prepared to accept; and it has taken a full week for me to reach the point where I am able to pass what I consider to be the appropriate sentence. In fact, to the parties' credit, what was to have been a two weeks ***Newton*** hearing has turned into a one week sentencing hearing. I have not heard evidence but have received submissions from counsel over two days; the rest of my time has been spent reading and trying to master the voluminous papers and preparing these sentencing remarks. It was agreed that I would reach my conclusions on the basis of the paper evidence and counsels' submissions. I should add this. I was referred, over the two days, to many documents and extracts. I was given three full lever arch files. I listened to submissions. And I took notes. I will not be referring to many of those documents and many of those submissions. That is not because they have somehow become lost; I have considered them all and, where they were of assistance, I have taken them into account in reaching my conclusions.

4. The background to this case is as follows. On 2nd November 2007, there was a warehouse fire at Atherton on Stour, Warwickshire in which, as already mentioned, tragically, four fire fighters lost their lives. There was then a long and arduous investigation involving different agencies. At the end of this investigation, which took several years, [redacted] as well as this charge under section 2 of the Health and Safety at Work &c Act 1974 against the Warwickshire County Council. [redacted]

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5. [redacted]

6. The charge against these Defendants was laid in January 2011. It is – and I choose my words carefully – unfortunate that justice in this case has been so delayed. I am assured that the crown acted as quickly as it could in getting these cases into court. The inquiries were extensive involving many thousands of hours of police time and the investment of several million pounds of public money. However, as time goes by, as the Court of Appeal has frequently remarked, justice delayed becomes justice denied. I agree with Mr Compton QC, who has appeared on behalf of the Defendant, that this delay must be reflected in my sentencing. Much water has passed under the bridge (perhaps I should say through the hose pipes) since these events occurred, many changes have taken place, and the persons who are responsible for the activities of this Defendant have changed. I say no more than this; that I am greatly concerned at the delay in this case. I do not point a finger of blame because it has not been part of my job to investigate the extent to which, if at-all, inquiries and investigations exceeded that which was necessary in the proper and proportionate pursuit of justice; nor do I have the materials to enable me to do so. But the delay in this case – caused for whatever reason – borders on the unacceptable. [redacted]

7. If I may be permitted a passing observation: It seems to me that one of the real difficulties here has been the proliferation of paper which has been generated in recent years both before and after the passing of the Fire and Rescue Services Act 2004. It has taken a lot of explanation from Mr Matthews QC, who has made himself an expert in the field of Health and Safety Law, to educate me upon the statutory and regulatory framework which lies behind the huge volume of directives, advisory notices, operational procedures, and the many thousands of pages of other documents which we have had to consider in the course of this case. Little wonder that one of the witnesses in the case commented that he would like the fire fighters' manual to be reduced to the size which it was a few years ago and to be made simpler. Can a fire fighter, attending a fire in an emergency situation, remember what the picture on page 138 of the manual was intending to convey, how and when he should conduct his dynamic risk assessment, and which of the elements of the flowchart he should move between before forming his decisions? There are many obvious deficiencies in the paper work. Many of the ever increasing numbers of directives and other papers are couched in language which borders on the impenetrable. We have found internal contradictions and entirely different flow charts purporting to show the same thing. In the course of the trial earlier this year, we spent much time debating what a particular directive or advisory note was intended to mean. There is no time for debate at the fire ground.

8. I suspect that one of the difficulties in bringing this case to court expeditiously arose from the needs of the prosecution authorities to satisfy themselves of this underlying regulatory framework. It is not surprising that there is confusion as to what the duties are (for example about training) where the obligations lie and whether or not there were breaches. Even in the course of the hearing this week I have had submissions and counter submissions upon a host of issues where counsel have disagreed as to what the regulations (for example) were purporting to say.

9. The short point is this. It just seems to me that the confetti of regulatory and other advisory papers, intended to improve safe systems of working, is capable of being obfuscatory and counter productive. It has also contributed, I suspect, to the delay. It has certainly contributed to the length of court hearings.

10. Today I have to pass sentence on Warwickshire County Council – it being acknowledged that the Council is the employer of the service personnel that make up Warwickshire Fire and Rescue Service which is a department (or in old language a Brigade) within the Warwickshire Fire and Rescue Authority. For the purposes of what I am about to say I propose to regard WFRS and the WFRA as being interchangeable and will try to refer to them hereafter, whether individually or collectively as The Authority or as the Defendant. As I have already mentioned, the Defendant pleaded guilty at the first opportunity.

11. Before I move to sentence however, I need to make a number of remarks. In the mitigation advanced on behalf of the Defendants, Mr Compton QC said that the Defendant did not seek to blame the Incident Commanders in any way and that the "*decision to fight the fire offensively, given the clear instructions of the manager as to the nature of the fire and his instructions as to its location was the correct one.*"

12. The crown's case was the opposite. I consider that that is a crucial question which I should determine, because so much else flows from the decision to commit firefighters into the fire compartment. This was probably the main question with which the jury at the first trial had to grapple. [redacted] This is now a sentencing hearing and it is for me to make that decision. I have reached the firm conclusion that it was a correct decision; that offensive fire fighting was entirely appropriate in the circumstances which existed on the fire ground that night.

13. Because this is an important matter, I propose to explain my reasons for reaching that conclusion.

14. I remind myself that there were in this case many experts other than Dr Dennett. The Defendants commissioned an expert report from Mr Roger Day and called him to give evidence. He disagreed with Dr Dennett. But all those who attended on that day were qualified fire fighters, also experts. Prosecution witness after witness went into the witness box and – with a singular exception – spoke in support of the decision to commit men to locate and fight the fire within the compartment. Firefighters Hodge and Matthews went into the fire compartment on two separate occasions. Both of them were of the same grade as two of the three incident commanders and both of them expressly stated that they would have taken the same course if they had been incident commanders; so too Mr Laight who went in wearing breathing apparatus; so also others who were responsible for the BA entry point, hose management, water management; all experienced fire fighters with many operations behind them. All trained and experienced men. Messrs Hodge and Matthews were content to go into the compartment for a second time and, if their shift had not been coming to an end, would have gone in for a third time. Only the hugely inexperienced Mr Holt, a retained firefighter who had only just qualified to use breathing apparatus and who had never previously been on BA duty at a fire was not comfortable with the decision that had been made. Others who arrived at the scene supported the decision to a man. Dr Dennett's was otherwise a lone voice. I know that there has been a suggestion (not made in court) that other fire fighters were "closing ranks" in support of their colleagues. But my own assessment of their evidence was that they were all genuine and truthful in expressing their opinions that correct decisions were being made and that they would have made the same ones.

15. But there are other reasons why I reach that crucial decision – a decision which will underpin my sentencing of this Defendant. First, I regret to say that I found Dr Dennett to be, at least in some respects, an unacceptable witness. [redacted] I judged that he was not a fair or balanced witness. There were numerous examples which I could give of occasions where his evidence, in my judgment, was

unacceptable, coming as it did, from an expert witness called on behalf of the crown with the duties of fair and balanced reporting which that carries. He was unfair when cross examined about sandwich panelling and was reluctant to make proper concessions, as I well remember. [redacted]. I could give other examples of evidence where he was just unacceptable.

16. There are other reasons why I agree with the submission which Mr Compton QC has made about this. It is clear to me from the manual (and for good reason) that the normal fire fighting mode was to be offensive as opposed to defensive. Unless a properly conducted risk assessment suggested that it was too dangerous, this was the default position. As at the moment when the four deceased men were deployed into the compartment, there was no reason to think that offensive fire fighting should not be the proper course. Others had been in and had reported back; experienced fire fighters, [redacted] had not considered that there was any reason for them not to return to the compartment. Of huge importance were two further factors. Men being deployed would be in the best position to determine whether or not it was safe to continue. They were required to do their own risk assessment (I decline to use the word "dynamic") and were under standing instructions to retreat to safety as and when that moment occurred. They had a hose pipe pointing the way out. Theirs was a primary duty to take care for their own safety. They possessed that duty under the Act. Nobody could possibly have foreseen that they would not return before conditions made it unbearable for them to continue. They were in the ideal position to appreciate any danger, present or impending. Unlike the First World War soldier, they were entitled and encouraged (indeed had a duty) to return to the trenches long before they were at risk of death. [redacted] Their own obligation was to participate in the safety process. I repeat, there was no compulsion either to go in or to stay in.

17. I could deliver a long judgment about this. I mention only one other matter. As was repeatedly said, during the course of the trial, this was a fire within a building. When the first tenders arrived – and for some considerable time afterwards – the building itself was not on fire. What was reported was a single pallet fire in the first floor storage area. Defensive fighting would have involved standing by, discharging water from a distance and waiting for the building to catch fire. The first obvious step – and one with which all except Dr Dennett agreed – was to try to put the fire out, provided, of course, that it could be safely done. Risk assessments were made by all at the fire ground and – for the reasons I have mentioned earlier – there was no reason to foresee the possibility that fire fighters entering the building might be unable to withdraw at any time that they required to do so.

18. I am also impressed by the fact that those who are now responsible for the Warwickshire Fire and Rescue Authority, looking back at events that night, continue to hold that view. The Authority has undergone a massive overhaul since these tragic events. It is, on any view, a model for other authorities with new people in charge, having made huge investments in improving safety. But, even with the benefit of retrospective vision, they hold to that opinion.

19. I apologise for explaining my reasons so fully, but this is a crucial finding. And, of course, when it comes to sentencing, it is for the judge to determine the factual base. He is in a better position to do so when he has been in charge of the trial and been able to assess the evidence.

20. ***The post accident actions of the Authority.*** Immediately after the fire, the Authority commissioned a senior officer from the Hertfordshire Fire and Rescue Service, Roger Day, to undertake an investigation into the fire. This was carried out in accordance with a protocol agreed with the police in order to protect the integrity of their investigation. As a consequence the investigating team were not given access to evidence gathered by the police and were not allowed

to interview any witnesses. Nevertheless, by August 2008 a report had been completed making numbers of recommendations. At this point I am told that the police seized the report and instructed Hertfordshire FRS not to allow the Authority to have or see a copy (except for one chapter) until 2011 when it was released as part of the disclosure of the Prosecution evidence.

21. I am also told that the Authority agreed to give day to day control of the investigation of the origin and development of the fire to the Police, who promised that the Authority would be provided with a copy of the Fire Investigation Team's report as soon as they had it. However, when the report was ready, the Police would not provide it to the Authority and this too was not seen until it was supplied as part of the Prosecution disclosure in 2011.

22. I say no more about those matters because I have not investigated them and do not know the reasons for those decisions taken by the police; decisions which I know (from what I heard at the first trial) have contributed to a souring of relationships between the Fire Service and the Police force. I hope that those relationships are now mending. I mention them only because I am satisfied that since 2007 the Defendant has reformed in a most impressive way its risk management systems, training and equipment. It did this in spite of the difficulties caused – for good reason or bad – by the attitude of those conducting the police inquiry.

23. The reforms have been made in the three areas of complaint which have been advanced by the crown. I pause to note what those three matters are.

24. The crown's case as opened included this: "*It is the Crown's case that (there was) a systemic failure to take all reasonably practicable steps to:*
    - *Provide effective systems for gathering and promulgating premises risk information to firefighters.*
    - *Provide effective systems for gathering and promulgating information related to the supply of water.*
    - *Provide effective systems for the training of firefighters which included effective monitoring of that training and assessment of competence.*"

25. Three areas of complaint; a failure to gather risk information in respect of premises within the boundaries of its operations; the same failure in respect of locations and other information about water supplies; and a failure to undertake adequate training of firefighters, to record and monitor that training properly.

26. Those areas of complaint are accepted on behalf of the Defendant, albeit that there are disputes as to the full nature and effect of the failures. I will return to those differences in a few minutes. But what is important for the moment is that I am entirely satisfied – and I believe so are the crown – that there has been full rectification of those matters and that the systems, in all three areas, are now in full and proper health. I will summarise the case in those three areas.

27. ***As to* the failure to gather and have available for crews important information about premises**, the crown case, as opened, was that "*there was a longstanding and widespread failure to gather, assess, record and promulgate safety critical risk information required by the Fire and Rescue Services Act as one of the Fire Services' core tasks. It is the Crown's case that this was a fundamental failing on the part of the Authority.*" This failure has been acknowledged on behalf of the Defendant. It is acknowledged in this way: "*WFRS was not informed as to the relevant circumstances of the Building, by the use of an O2 Premises (Risk) card or familiarisation visits; WFRS failed sufficiently to monitor the O2 process at the time of the incident*". That was the acknowledgement. This failure has now been fully rectified.

28. ***As to the failure to gather information in respect of water*** hydrants and other water sources and have that information available for fire crews, the Crown's opening contained this: "*The system that the Authority had in place wholly failed to ensure that Fire Service Control and operational crews*

had adequate and readily accessible information about the locations of viable water supplies." Leaving aside the use of the word "*wholly*", there is little between the parties upon this and it is agreed that the gazetteers were not kept up to date as service orders required them to be. This also is a failure which, I am entirely satisfied, has been fully rectified.

29. **As to the failures in respect of training**, it was the crown's case as opened by Mr Matthews QC that *"There was a widespread and longstanding failure to provide effective systems for the training of firefighters, which included effective monitoring of that training and assessment of competence, such that the provision of training and ensuring of competency were seriously deficient"* He included an assertion that *"the paper based records of training for retained firefighters were poorly maintained and failed to provide a basis for assessment of training needs ..... there was insufficient monitoring of the content and delivery of training and the competency of firefighters .... and there was a failure to ensure the developmental and ongoing training of whole time firefighters"* He also said that *"The Authority failed to deliver competent firefighters who were fully versed in the practicality of wearing breathing apparatus and in the application of command and control procedures, incident command competence was not assured to the extent that some officers were ill equipped to set up and maintain the high degree of management required to deal with BA operations, incident command and the general complexity of an incident."*

30. Here, there is a much larger gap between the crown and the defence. In summary, the Defendant accepts that the record keeping and monitoring of training was defective but denies that the training itself had any real deficiencies. Again, I will need to return to this. But for the moment it is sufficient to record that in this (third) area also, there has been full rectification. In determining the extent of the Defendant's culpability, I will need to consider and – at least to some extent – resolve these issues.

31. First, however, I should say a word or two about the way in which these deficiencies – as I say in the three areas of complaint – have been rectified. Impressive new computerised systems have been put in place. Mobile Data terminals are available to all operational crews from which all information re premises and water supplies can be accessed both at the fire ground and en route. The database is constantly updated in fact twice daily. Sophisticated systems have been put into place to identify and survey premises other than residential premises and to create risk assessments. In this respect I am told that there has been a full review and maintenance of risk premises information with 2,344 buildings currently having been assessed and recorded All water sources have been identified, mapped and placed into the system. This has been achieved through a computer programme (Aquarius) which is available via the terminals. As to training, the full recommendations made in the report, finally released to Warwickshire in May 2011, are being implemented. Training is recorded on the rejuvenated Redkite system and specialist training is provided in various specialist areas such as Incident Command training and Breathing Apparatus and Fire Behaviour training. That, I know, is an inadequate summary of all that has been achieved; but I am grateful for the detail which has been provided to me.

32. I need to consider the nature of the breaches which have been established against the Authority and the extent of the failures.

33. As to identification of water supplies, there is no dispute. The location of nearest water supplies was unknown to those who attended at the Atherstone fire. There were no maps or other information on the tenders available to the crews. The person who was responsible for the premises on behalf of the owners imparted the information which he had to the incident commanders on the night. That was Mr Tenney, who gave evidence at the trial and who will be mentioned later in these remarks. This was a generalised failure for which the Defendants accept responsibility.

34. There is also little dispute now about the inadequacy of the systems for gathering risk information about premises and having it available (in fact in the form of so called O2 cards) at the time. Records and cards were generally deficient albeit that there was much information about many premises within the area. There was no O2 card in respect of the Atherstone premises. On the other hand some of the evidence gathering on behalf of the prosecution turned out to be flawed and

Mr Compton was able to demonstrate this to me by taking me to the core documents. But it was a small point and I do not need to dwell upon it. It is a failing which is accepted as a broad criticism. I can mention the example of sandwich panelling which featured also at the trial. The warnings which should have been passed on to crews about the potential dangers of sandwich panelling and its propensity to feed a fire were not in fact passed on. The sandwich panelling in these premises fortunately was of the fire resistant variety and was not causative of any danger. But the point is still a good one.

35. At the risk of repetition, the Defendant accepts that in 2007 it was failing in its duty to have a comprehensive premises risk evaluation programme and to ensure that crews had access to such information. This is the one failure which the Defendant accepts *may* (I emphasise *may*) have contributed to the deaths.

36. Finally: training. Here, the Defendant admits that records were inadequate albeit that there were many records contained within the Redkite system which the prosecution had not managed to find. The prosecution opening contained many assertions of fault, paragraph by paragraph. On behalf of the Defendant, Mr Compton QC made reasoned and detailed answers to each individual point. I do not propose to go through these in any detail; to do so would take up several hours and would achieve little purpose. I have been through them with some care and analysed some of the evidence. Mr Matthews' opening contained – as I have noted – many detailed criticisms. This part of the opening occupied many pages and it may be noted – and I do note – that the parties started from fundamentally different positions as to the requirements of training under the Act. I propose to say this. First I am satisfied that there were omissions in the recording of training and the signing off of competencies; those failures were not as extensive as the crown asserted partly because the Redkite system had been misunderstood by those who searched it on behalf of the crown. In broad terms the Defendant has satisfied me that its training back in 2007 was – to put it at its lowest – satisfactory.

37. In reaching this conclusion I take this into account. Where I have been able to check the crown assertions and the defendant's responses, I have found Mr Compton's analysis to be correct. I could give a number of examples but I need to be selective.

38. An example may be found at paragraph 51 of the Opening where Mr Matthews QC stated "*It is apparent that RDS Officers responsible for setting standards and training at station level may have received little more formal training than the recruit.*"

39. There was, as Mr Compton pointed out, no evidence for this. The responsible body for the delivery of training is the Fire Authority and the training may be delivered in a variety of ways. The standard is set by the Fire Authority and it was just unfair comment – unsupported by evidence to suggest that RDS officers were either unable to deliver adequate training or had themselves been inadequately trained.

40. It was further asserted at paragraph 52 that "*A detailed analysis of the paper training records (PDTR) of ten retained firefighters (including those for Ian Reid and Darren Yates-Badley) who had been present at the fire on 2 November 2007, revealed, at best, partially completed records without proper management oversight, which, if they had been considered by someone with a view to assessing the competence of the firefighters, could only have lead (sic) to the conclusion that the firefighters were poorly trained.*

41. Examples were given. I refer to just three of them:

- *"No records of competence have been completed in any of the paper training records".*
- *"There are inconsistencies between the training recorded in the individual paper training records and the watch training record.*
- *"The paper training records have not been completed contemporaneously."*

42. As to the first, this assertion was simply wrong and I was referred to the documents which not only record that which is said to be unrecorded but which also contain the legend: *"The record of*

competence should only be completed for training which has been assessed. The majority of training sessions will not be assessed and therefore only the Record of Training completed – practical should be completed" Exhibit 53 contains the paper records for a further six RDS firefighters and all six of them have their Record of Training completed as required. Firefighter Laight also shows entries under records of competence as required when assessed. As to the second assertion, Mr Compton was able to point out that the inconsistencies had been fully explained – as I am satisfied they have. There is an analysis within the Defendant response bundle which I have considered carefully and find to be wholly persuasive. As to the third assertion, exhibit 42 (training review 2008) upon which it seems the crown relied to make the assertion in the first place appears to show the contrary. There are several examples of records expressly stated to *"have been filled in contemporaneously"* and to *"have been comprehensively and contemporaneously completed"*.

43. A further example if I may. At paragraph 55 of the opening the following was said: *"A detailed review was undertaken of the records held at Alcester station in which a summary of the training given to the watch as a whole was recorded for the period April 2006 to October 2007 (84 weeks). This revealed that although there was a nominal two hours per week identified as "drill night" for Retained firefighters, the investigation has established that the portion taken up by training was significantly less than two hours per week."* Mr Compton was also able to answer this unfounded criticism. The requirement is for RDS firefighters to attend at the station to which they are attached for duty for training, development and maintenance duties for an average of two hours per week. It is clear that the crown has discounted duties other than simple training. Other activities qualify. When analysed in this way, there was compliance.

44. I add only a small comment of my own at this stage. This is form over substance when viewed in the context of the charge under the Health and Safety at Work Act where the requirement is (I remind myself) to ensure so far as reasonably practicable the health and safety of employees. How can it be said that training is inadequate if it is just under two hours or adequate it is over that time? It would no doubt be reasonably practicable to provide lengthier training for those who needed it.

45. Finally the criticism made at paragraph 56 does not bear investigation: *"Analysis of the drill nights at Alcester Fire Station when Breathing Apparatus training had been recorded revealed that none of the BA training was supervised by a qualified Breathing Apparatus Instructor."* There is no reference to any regulation which requires on-going training to be so supervised. It is bare assertion as with so much else in relation to training. Some of the criticisms (see for example paragraph 63 of the Opening) have been based upon the failure of Mr Ingledew and his team to understand and properly interrogate the Redkite system. I have considered his up to date comments which do not persuade me otherwise.

46. I reach the following conclusion. I cannot be sure that all training was carried out or that it was perfect. I can be sure that records were to some significant extent defective and it might thus be an appropriate inference that compliance with training requirements may have been less than perfect. However, I am entirely satisfied that there has been much unjustified criticism and that appropriate training was – for the most part – carried out. Record keeping was not good and that is in itself a significant failure.

47. I should mention the evidence – albeit briefly – of Mr Rule. There was to have been a dispute between the parties as to whether that evidence should be admitted. I read the evidence *de bene esse* and took the view that it was a dispute which I did not need to resolve. I note a number of things and will then move on. I have reached my findings in spite of some opinions to the contrary which Mr Rule expresses. I do so having reminded myself of the direction a judge would give to a jury in respect of expert evidence. Some of Mr Rule's opinions are plainly based upon flaws in the core evidence (in respect of training for example) to which I have just referred. I take account of the fact that Dr Dennet and Mr Rule – both experts put forward on behalf of the Crown – differ in

respect of some opinions (I appreciate not opinions relevant to this hearing). And I note that each of them was dismissive of the other's expertise. At a time, I think, when they were to be on opposite sides at the trial, Dr Dennet had said of Mr Rule *"I doubt Mr Rule's claim that he has practical experience of attending many major fires in circumstances not dissimilar to that which ... occurred at Atherstone on Stour. In my opinion he has very limited fire fighting command experience in general and none involving fires in large and complex buildings"*. Of Dr Dennet, Mr Rule had said *"within his report I have identified areas where the evidence presented by Dr Dennet has, in my opinion, been incorrect, selectively quoted and incompatible with some other statements made, sometimes by the same individual, or appears to be factually inaccurate or unsubstantiated by the evidence."*

48. I make my findings notwithstanding some of the opinions expressed by Mr Rule. I am aware that I have not heard his evidence and accordingly I leave it there. I cannot say what concessions he would have made if cross examined upon a number of opinions which, it seems to me, would have been unsustainable. For example in determining whether a supposed failure of training had contributed to the deaths, I consider that I am in just as good a position as he is to reach a conclusion; perhaps better having presided over a trial which he did not attend. I leave it there.

49. The next important decision is whether or not the three failures or any of them was causative of death. To put that another way, did any of the three failings make a material contribution to the deaths of the fire fighters. I remind myself of the respective positions of the parties. The Defendant accepts that there may have been a causative link between the failure to gather information about premises and the deaths but denies that any other failing made a contribution. In opening Mr Matthews QC said, *"It is the Crown's case that the offence is aggravated by the breach having been a substantial contributing cause of the deaths of four firefighters at the premises of Wealmoor (Atherstone) Ltd on the 2nd November 2007."*

50. On behalf of the Defendant, Mr Compton QC made the following opening submission: *"We invite the Court to accept that the tragedy that unfolded on the evening of 2nd November was a result of a series of exceptional adverse factors; in particular the Court is reminded that this was an arson attack in an incomplete building and where respective owners failed to comply with, inter alia, the Building Act and Building Regulations and the Regulatory Reform (Fire Safety) Order 2005 ("RRO") and where many of the critical intended fire protection measures were missing such as means of escape."*

51. I remind myself of some of the background facts. The owners and occupiers had sidestepped the Building Control Regulations and had occupied the first floor of the premises, using it as a storage area, at a time when the building was incomplete The planned sprinkler system was not in place, some parts of the structure had not been fitted with the planned fire resistant materials and, most importantly, the two fire escapes, one on the north side of the building and the other on the south, had not been installed. Stratford District Council, the responsible authority for this purpose, had not been notified and this was a breach of the Regulations. Perversely, by express statutory provision, the occupiers owed no duty to the deceased men. This would not have been the case when the Factories Act and the Offices Shops and Railway Premises Act were in force and when duties and requirements were spelt out with some precision. It is also an unfortunate fact that the various planning and building control applications which had been made were not notified to the Authority (WFRS) nor were they consulted. There had been a minor incident at these premises some months earlier when Mr Simmons had attended and had spoken to Mr Tenney. He had noticed a gap in the wall – the single entry point from the office area to what had now become the storage area, where fire doors were to be installed. Those promised fire doors had never been fitted. Mr Tenney informed the court that he had made requests and complaint about this. To compound matters, Mr Tenney, who was present at the scene when the fire crews attended, gave wholly false information as to the position and nature of the fire albeit with the best of intentions.

52. In my judgment it is entirely clear that the absence of water information had no bearing on this case at all. There was at all times an adequate water supply and no different course would have been taken if the location (for example) of the nearest hydrants had been known. I do not now understand the crown to be contending otherwise.

53. As to training, I am equally clear that there can be no causative link, finding as I do that (i) the training deficiencies were largely concerned with records (ii) the decision to begin offensive fire fighting was a correct one and (iii) nothing that happened that night would have been affected, even if the crews had received the levels of training which are now provided.

54. The O2 card system was undoubtedly not operating correctly and the Defendant has made the concession that the lack of an O2 card for these premises may have been a contributory factor. If so, it was, in my judgment a minor one and is of little weight compared with all the other unfortunate and unforeseeable factors, some of which are mentioned above. An O2 card system cannot provide insurance against matters such as the use of the premises in breach of building and planning controls and so on. It cannot provide guarantees against inaccurate information being given at the site. Depending upon when it had been updated, an O2 card may have pointed out the absence (yet) of fire escapes, but, if they were not in place, the alternative means of entry would have been used, if and when the offensive fighting mode was adopted.

55. If it needs me to say so, this dreadful accident was caused, as so many accidents are, by a series of mishaps occurring together, by a whole host of causes, some being more potent than others. The causes may, to some small extent, have included the absence of O2 records.

56. In the light of these comments, what is the appropriate sentence? There is much further mitigation which I have not yet touched upon. I mention it briefly now.

57. It is an interesting feature of this case that, prior to the incident, the Authority had been assessed as performing at least adequately and in some respects well above average. These assessments included an inspection of the Audit Commission which had rated performance as good, with many aspects of service delivery graded as *"consistently above minimum requirements"* and *"well above minimum requirements, performing strongly."* It also included the HSE's inspection in 2005, where the Summary included: *"Overall, WFRS demonstrated a positive attitude and strong commitment to managing and controlling health and safety risks."* There was also a wholly positive report from RoSPA albeit in early 2008. This was, however, before the massive improvements had been put in place.

58. I have already mentioned those improvements but should add that I am satisfied that the training is now regarded as some of the finest in the country

59. There are other matters which need to be mentioned. The incident occurred over five years ago and the management team now is completely different. There has been this long delay which, as I have already mentioned alters the sentencing landscape.

60. For what it is worth, the Defendant has no relevant previous convictions or cautions recorded against it. Unlike many health and safety offences, this is not a case where an offence has been committed in the pursuit of profit; a guilty plea was indicated and entered at the first available opportunity, and there was full cooperation with the police investigation. All requests for information and evidence by the Police were answered promptly. Indeed evidence not otherwise unearthed by the police investigation was volunteered.

61. Finally I should note that notwithstanding arguments that could clearly have been advanced, the Defendant has admitted full liability in all civil claims.

62. I turn to the principles of sentencing. I record that I make full allowance for the early guilty plea and I have in mind the case law concerning fines to be levied against a public body as against a private profit generating business. In the ***Milford Haven Port Authority Case***, [2000] Cr App R (S) 423, Lord Bingham CJ said: *"It would be wrong to suggest that public bodies are immune from appropriate criminal penalties because they have no shareholders and no directors in receipt of handsome bonuses. The policy of Parliament would be frustrated if such a notion were to gain currency. But, in fixing the amount of a fine it is proper for a judge to take all the facts of the case into account..... The judge has to consider how any financial penalty will be paid. If a very substantial financial penalty will inhibit the proper performance by a statutory body of the public function it has been set up to perform that is not something to be disregarded. In the present case there is nothing to suggest that the cost of any fine can simply be recouped from customers by raising the charges."*

63. My approach is this. If the water recording deficiencies had come to light as a result of a general safety audit by the HSE and a decision had been taken to prosecute, an appropriate fine might have been – as it seems to me by making some comparisons with other cases – around £5,000 - £10,000 after an early guilty plea. The same might apply to the lack of training records, although there the default might be considered more serious and the fine the greater. I see no reason not to take that approach, satisfied as I am that these were failings which did not in any way spill over into the events of November 2nd 2007. The O2 card failure is the more serious. It seems to me to be obvious – whether one accepts the causative nature of the failure or not – that this is an important requirement; that risk premises should be assessed and that to be forewarned is to be forearmed. Doing the best I can and discounting as I must for the early plea and the full cooperation of the Defendant, I propose to fix a total fine of £30,000. I note that, quite properly, no application is made for costs.

64. Finally I want to repeat something which I said at the beginning. The loss of life which occurred all those years ago was a terrible waste. It has brought unimagined grief and a search for causes and answers. If anyone should say – as one sometimes hears reported – that the court has undervalued a human life, let it be understood. There were many contributory causes of these deaths. It is highly unlikely that anything done or not done by this Defendant would have affected the outcome. I have had to keep an unblinkered eye on the ball and assess the real culpability and leaving sympathy and other emotion out of the equation. There is little or no linkage between this fine and those deaths.

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The Honourable Mr Justice MacDuff

7th December 2012