IN THE CROWN COURT AT CHESTER **T20197350**

The Hon. Mrs Justice May DBE

BETWEEN:

REGINA

-and-

(1) WOOD TREATMENT LIMITED

(2) GEORGE BODEN

SENTENCING REMARKS

Introduction

On Friday 17 July 2015 at around 0900 there was a massive explosion and fire in the wood treatment plant at Bosley Mill, situated outside Bosley village, south of Macclesfield on the River Dane. 4 of the 50-strong workforce lost their lives in that explosion: Derek Moore, (Derek) Will Barks, Dorothy Bailey and Jason Shingler. Others received life-changing injuries. The body of Jason Shingler was never recovered. The force of the explosion and the ensuing fire devastated large parts of the mill buildings. Search and rescue operations mounted over the course of the next weeks sought to locate any survivors and, when they found none, to retrieve the bodies. The workforce at Bosley Mill included many members of the same families; the shock and grief at the loss of 4 people - mother, sister, aunt, husbands, fathers, brothers, cousins and friends - and the serious injuries to others reverberated widely at the time and has continued over the past 6 years.

The Mill was operated at all material times by the First Defendant, Wood Treatment Limited (WTL). WTL had been incorporated in 2008 for the purposes of acquiring the site and business. Under its previous owners the business had gradually failed and had finally been put into administration. WTL acquired it from the administrators. Under WTL, the business of producing wood dust and associated wood products continued. Machines for drying, grinding, sifting and other manufacturing processes were located in the many rooms of the main Mill building

and in a variety of other outbuildings and sheds on the site, with numerous pipes and conveyors running inside, outside and between them. The products made at Bosley Mill included various grades of wood dust, from coarse (5 or 10 mesh) to fine (120 mesh), also wood pellets for animal litter. It was a 24 hour, 5 day a week operation, although the machines would sometimes also be operated at a weekend if orders required.

The Second Defendant, George Boden (GB), is the eldest of the three brothers whose family business, Boden & Davies Limited, incorporated WTL for the purposes of buying Bosley Mill from the administrators in 2008. The business of WTL was initially overseen by a Mr Andrew Lowden, as Managing Director (MD). Mr Lowden left and GB took over as MD in 2011. From then until the explosion GB was MD of WTL, also Director with overall responsibility for Health and Safety. He attended at the Mill most days, taking a hands-on role in the business. His younger brother, Charles Boden, was also a director of WTL and would visit the Mill regularly; he appears to have been in overall control of the finances.

The terrible explosion on 17 July 2015 was the occasion for an investigation of the manner in which the business at Bosley Mill had been operated and gave rise, ultimately, to the counts which these defendants faced at trial.

When the trial started the charges against WTL and GB included 4 counts of corporate manslaughter and gross negligence manslaughter respectively, the Crown's case being that WTL and GB bore criminal responsibility for the deaths of the 4 employees who lost their lives in the explosion. For reasons which are set out fully in my ruling given on a defence submission of no case to answer, and in the Court of Appeal decision upholding that ruling, the Crown's case on the evidence was insufficient to support the manslaughter charges. There was no option but to direct the jury to return not guilty verdicts on those charges.

What remained against each of WTL and GB was a single count of breach of a duty to ensure, so far as reasonably practicable, the health and safety of employees at the Mill, over a 6 year period between 2009 and the explosion in July 2015. The charge against the company was brought under Sections 2 and 33 of the Health and Safety at Work (etc) Act 1974. WTL pleaded guilty to this offence on first arraignment 2 months before the commencement of trial, but on a basis under which the company

accepted some failings over the 6 year period, but not such as to cause the explosion resulting in the deaths on 17 July 2015.

Following his acquittal on the manslaughter charges to which I have already referred, GB pleaded guilty to the remaining count, charging him under Section 37 of the 1974 Act with being a director of a company which had committed the relevant offence under Section 33.

Factual basis for sentence – criminal standard

WTL and GB now stand to be sentenced for these offences. The factual basis upon which they are to be sentenced is for the court to determine, having heard the evidence at trial over 7 full weeks. There are two important matters for the court to bear in mind in making the necessary findings: first, I must be satisfied of any matter to the criminal standard, that is to say I must be sure. Second, I am bound by, and must stay true to, the acquittals directed in respect of the manslaughter charges, and to the basis of those acquittals, which is that the Crown did not succeed in establishing the necessary causative link, to the criminal standard, between negligence on the part of WTL and GB and the explosion which led to the deaths. In short, I cannot sentence either defendant on the basis that their action or inaction caused the deaths of the four employees on 17 July 2015.

WTL

In sentencing WTL the court is required to apply and follow the steps set out in the Sentencing Council Guideline entitled

Organisations: Breach of duty of employer towards employees and non-employees/ Breach of duty of self-employed to others/ Breach of Health and Safety regulations

I turn first to Culpability. I conclude that WTL's breaches fall at the higher end of High (falling far short of the appropriate standard). I have reached that view because:

(1) WTL consistently failed to fulfil the requirements of the Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) over many years. For 2 of the 6 years, there was a competent person, Sheila Jones, engaged to advise WTL on Health and Safety. With the encouragement of GB

she embarked on the exercise of drawing up all the necessary risk assessments, in the course of which she made a number of recommendations for improvements at the Mill; some were implemented but by no means all. When she left in 2013, WTL appointed no one to replace her.

(2) Whilst a certain level of dust accumulation was inevitable, given the business of the Mill, there was no systematic programme for monitoring or cleaning up the dust, particularly fine dust which gathered at high levels. The photographs taken, for different purposes, by a number of contractors and consultants visiting the Mill over the years, and employees, clearly demonstrate unacceptably high levels of dust being left to gather on beams, rafters, conveyors and pipes in rooms and sheds around the site. It was particularly, repetitively, bad in the area called Riverside. As an example of the way in which regulations were ignored the evidence indicated that on at least one occasion when Riverside was being cleaned, in May 2015, GB opened a hatch in the floor, with direct access to the River Dane, and directed employees to sweep the huge piles of dust down there and into the river. There was a video, taken by another employee, of large amounts of dust going into the river.

(3) Just one person, Dorothy Bailey, a lady in her 60s, was employed to clean the entire site; even a cleaner as hard-working and diligent as Mrs Bailey clearly was could not possibly have been expected to achieve the necessary standard. It required a team of full-time cleaners.

(4) The team of engineers and mechanics responsible for maintaining the integrity and functionality of the equipment at the Mill were experienced. But the equipment itself was old and worn and dust leaked from it. There needed to be a far more reliable and routine system of repair and maintenance – proactive, rather than reactive. In 2015 David Paul Bailey was appointed to introduce more up-to-date computerised systems for the purposes of monitoring the repair and maintenance more closely, however this could not have addressed the staff concerns, which I accept, relating to delays in getting necessary parts to keep the machinery in working order.

(5) Two systems at the Mill were critical to ensuring health and safety: (a) the dust extraction system known as the LEV (local exhaust ventilation) and (b) the Firefly system. The purpose of the former was to extract dust from the air so as to ensure a safe respiratory level for employees. Firefly was a spark detection and isolation/suppression system designed (when it was installed long before 2008) specifically for the configuration of the machinery as it then was at Bosley Mill, although there had been some changes to the layout in the many years since first installation. Evidence at trial showed that neither system was inspected or maintained adequately. Although some inspections of the LEV system were commissioned, these were not as regular as they were required to be under the regulations, moreover the evidence of the external engineer who came to inspect was that very few of his recommendations were acted on, even where they were (repeatedly) highlighted as very urgent. The same defects were noted year on year, with nothing having been done. As regards the Firefly system, no approved Firefly service engineer was ever called out to inspect, still less annually as the manufacturers recommended. It is no answer to say that the system was tested once a week by a member of the maintenance team and that it was at all times operational. In fact the evidence showed that for a full 14months of the 6 year period, from Jan 14 to Feb 15 when the only employee having any familiarity with the Firefly system had left and before he returned, there was no one with the relevant expertise. At this time weekly checks were not always done and when they were done, it was by one young electrician, with no previous experience of the Firefly system, and an apprentice.

(6) Remaining with Firefly, the evidence showed that sparks were being detected and the system was being triggered more frequently as time went on. Bearing in mind that Firefly is not intended as a front line safety system, but rather as an emergency measure when, despite all precautions, a spark has entered the system, more regular Firefly alarms and trips should have sounded a warning bell about the integrity and safety of the mill processes generally, and should have been acted upon.

(7) There were visits from HSE in 2013, focussing in particular on the LEV system and levels of dust in the air impacting employees' health, resulting in

enforcement notices being issued. These were resolved upon WTL providing information about its systems, including assurances about cleaning and a written cleaning policy provided to the inspector. But the terms of that cleaning policy were never fully implemented. There was another visit by HSE in 2014 initially in response to a safety incident but which subsequently extended to concerns about dust accumulation and cleaning. On the occasion of the inspector's visit in October 2014 Riverside was taped off and she did not enter. The requirements of DSEAR were specifically highlighted and an enforcement notice served to ensure compliance. The inspector's evidence was that in March 2015 she was satisfied that WTL had taken the necessary steps to improve, amongst other things on the strength of assurances that the company had initiated a weekly leak inspection and also a deep cleaning regime as part of a regular maintenance programme. I am quite sure, on the evidence, that despite such assurances given to the inspector, these regular measures were not implemented at Bosley Mill.

(8) Concerns were raised about leaks and the accumulation of dust by employees on a number of occasions. As late as 2015 the chargehands refused to start up the machinery in Riverside until it had been cleaned.

(9) There were a number of occasions of fires, smouldering dust and – twice – relatively small explosions which were soon contained and dealt with. On one occasion two employees were injured in the drying plant when a fire started inside the drum when dust came into contact with a naked flame. The evidence of one employee injured in that explosion is that GB drove by, saw what had happened, swore and told them to get the machine back up and running. There appears to have been no subsequent internal investigation or recording of lessons learned, or indeed any changes in practice after these incidents. Incidents of smouldering in the pelleting machines happened regularly, up to and including on the day before the explosion.

It was the duty of WTL management, by which I mean the directors, to acquaint themselves fully of their obligations under all relevant legislation and regulations and to be proactive in meeting those obligations; they plainly were not, and did not. It was suggested to some witnesses that WTL responded readily and quickly to notices requiring improvement, for instance the notice requiring removal of piles of dust in

yards and roadways around the site in 2015, implying, perhaps that WTL was fully meeting its obligations under H&S legislation by doing so. If this was the intended suggestion then I emphatically reject it, as this would be to turn the requirements of Health and Safety legislation on its head. It was for WTL management actively to find out what the law required the company to do and then to do it, not to wait to be told about their obligations by HSE inspectors or anyone else. I have concluded so that I am sure that WTL was woefully wanting in discharging this basic obligation.

I turn to Harm, which comprises two elements: the severity of harm, if it occurs, and the risk of it occurring. All parties accept that the seriousness of harm, under the guideline, was at Level A. The prosecution suggest that, on the expert evidence of Mr Summerfield, there was a high likelihood of this harm occurring. Mr Kay for the company, supported by Mr Antrobus for GB, says that when properly understood, the effect of Mr Summerfield's evidence is that the risk of explosion was no more than moderate. Mr Kay directed me to the observations of the Court of Appeal in the case of *Tata Steel* [2017] 2 Cr App R (s) 29 at [44] relying on the fact that in the 6 years of WTL's tenure at Bosley, up to July 2015, there had not been any major incident of explosion, the only occasion upon which the Fire Brigade were called out being one of a spark causing a fire in a silo in 2010, 5 years before. Mr Kay also relied on the fact that on no inspection had the HSE been sufficiently concerned to order the closure of the mill, instead taking the lowest level of enforcement action.

I remind myself that I am required to be satisfied to the criminal standard. Taking into account the points made by Mr Kay, and bearing in mind the lack of a causative link between health and safety failures and the explosion in 2015 established by the evidence, I have concluded that the risk of harm was medium. However, having regard to the number of staff working at Bosley, in particular in the mill building itself where the main risk would have been (the rooms there being smaller and the dust produced being a finer grade) it is necessary to move up in the category range.

The combination of high culpability (at the higher end as I have said) and high harm together with the number of employees at risk in my view justifies taking a figure at the very top of the Cat 2 range applicable to micro-organisations, as the Crown accepts WTL is now to be regarded.

Turning to aggravating features, I find that there was an element of cost cutting at the expense of safety in the way WTL operated the business, albeit that this was not a widespread policy across the board. However the evidence established that there was delay in ordering necessary parts to mend leaks, a policy of "make do and mend" in respect of old machinery and holding back or not making payments, for instance in not replacing Sheila Jones when she left, or not paying a small bill to Firefly to enable a maintenance visit. On the other hand there was an investment in Green Goddess, a new piece of machinery that enabled Riverside to be closed, telling against cost-cutting.

As Mr Kay points out, WTL's health and safety record is the period of the offence, not a matter of aggravation of the sentence for that offence.

In mitigation WTL has no previous convictions. It is also a fact that, as a result of the explosion, the business at the Mill has ceased to exist.

WTL's current financial circumstances

WTL entered into a Creditors Voluntary Arrangement on 12 February 2016 and has remained under it since then. Insurers have to-date declined to pay out on the claim arising from the explosion, and WTL has brought a claim for in excess of £5m against its brokers. That claim remains to be resolved but I have seen evidence to suggest that the amounts owed to secured and unsecured creditors will outstrip whatever WTL may succeed in recovering. The second largest sum owed is to the family business, Boden & Davies, in the sum of £2m.

The site and business, which WTL purchased for £3.25m in 2008, is now worth no more than the value of the site alone, put at no more than £350,000 given the extent of remediation which will need to be done by any purchaser.

It seems highly likely, therefore, that WTL will in the end be unable to pay any sum ordered by way of a fine (other than a purely nominal one). I have been referred to competing authorities on the proper course to be adopted by a sentencing court faced with an effectively insolvent corporate defendant in these circumstances. However, in circumstances where I know only that there is an outstanding claim which may result in WTL obtaining substantial sums, I am not prepared to impose a purely nominal amount.

I allow a reduction of 1/3 for a guilty plea.

The sentence which I impose on WTL is accordingly a fine in the sum of £75,000.

The prosecution has made no application for costs, against either defendant.

George Boden

The applicable guideline for sentence in GB's case is the one entitled

Individuals: Breach of duty of employer towards employees and non-employees/ Breach of duty of self-employed to others/ Breach of duty of employees at work/ Breach of Health and Safety regulations/ Secondary liability

I have thought long and hard about GB's culpability in relation to the company breaches. As his counsel pointed out, he was at site every day, a hands-on director. He would therefore have been well aware of the conditions at the Mill. He met with inspectors when they came, as MD he received all the reports about the LEV and other systems at the Mill. He received regular reports, including oral reports, from Sheila Jones, who was very clear with him, I accept, about what the regulations required and what needed to be done to satisfy them. He may not have fully appreciated the significance, but he must have known, when she left, that WTL had not replaced her with a competent person as required by the regulations. He took inspectors round and either gave them, or heard others giving them, information about cleaning and maintenance that he must have known was aspirational at best.

The Crown suggests that GB's culpability is to be assessed as Very High, that he exhibited a flagrant disregard to what the law required. I was urged by Mr Antrobus to find that GB was no more than negligent, that is to say medium culpability albeit at the higher end. However balancing all factors and reaching, as I am required to do under the Guideline, a fair assessment of GB's culpability I find that it is High. I do not believe that he deliberately disregarded, wholesale, the law in relation to health and safety, but I am satisfied that he recklessly ignored what the law required the company to do, prioritising spending in other directions. I am sure that there were occasions where he did not do what he knew, as MD, he should have done eg appoint a competent person when Sheila Jones left, or insist on reviews of Risk Assessments which were out of date, but I am satisfied that at least by 2015 there was some attempt, albeit initiated by his brother, to modernise and introduce better systems at

the Mill. The change was very late, and it was not enough, but it had started. There had been, and continued to be, some very serious breaches of health and safety requirements but I am not satisfied that they amounted to a flagrant disregard of the law. GB was a totally inadequate MD, incapable, as the evidence showed, of understanding or insisting upon the introduction of necessary safety measures; the task was simply beyond him. He should never have been Health and Safety Director, still less Managing Director, of a business which required a very much more knowledgeable and effective hand on the tiller.

Harm is at the high end of level A moderate risk, as I have already found in connection with WTL, putting it into Category 2.

There is some very moderate aggravation by reason of the cost prioritisation measures I have already identified.

In mitigation I take account of GB's age, his lack of any previous convictions, his evident remorse and the fact that he is primary carer for his elderly mother.

There is a small discount of 10% to be applied by reason of GB's late plea.

The sentence is one of 10 months custody reduced to 9 for the plea. I am quite satisfied, applying the Imposition Guideline taken together with the Guideline applicable to this offence that it is appropriate to suspend the sentence. It will be suspended for a period of 18months.

The Guideline provides that, where a sentence is suspended, a fine may also be imposed where the offender has resources from which a fine can be paid. In the health and safety case of *Butt* [2018] EWCA Crim 1617 the Court of Appeal noted that for many a substantial fine coupled with a suspended sentence will be an appropriate punishment. I propose to take that course here. In deciding what fine to impose I have before me financial information relating to GB's income and outgoings, savings and capital assets. Taking all that I have heard about him into account the fine will be one of £12,000.

Given the conclusions I have reached about GB's suitability to act as a director I am quite satisfied that it is necessary to make an order disqualifying him from acting as one. He will be disqualified for a period of 4 years.

Stand up please Mr Boden

The sentence of the court is as follows:

You are sentenced to 9 months custody which will be suspended for a period of 18 months. This means that if you do not commit any further offence over the operational period of 18 months you will not be required to serve the sentence of 9 months. If you do commit any further offence the 9 months may be activated and added to any other sentence.

You must pay a fine of £12,000, payable within 12 months, in default of which the sentence is 9 months.

You will be disqualified as a director for a period of 4 years.

The court will draw up the necessary victim surcharge orders