

# UK ESH Spring Webinar

## Health and Safety Updates 2020

Tuesday 21 April 2020

9:30 – 11 a.m.



# Welcome & Introduction



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# Employer's health and safety duties during the COVID-19 pandemic

# Rob Biddlecombe





- Duty on employers to ensure so far as reasonably practicable the health and safety of employees at work and non-employees (contractors, members of the public, etc.) who may be affected by employer's undertaking.
- The key to compliance is reducing the risk to as low as reasonably practicable.
- Duty on employees to take reasonable care of their own and co-workers' health and safety, and to co-operate with employer on health and safety matters.
- Management of Health and Safety at Work Regulations 1999
  - Duty on employers to carry out a suitable and sufficient assessment of risks posed to employees at work and non-employees arising out of employer's undertaking.
  - Employer's duty to put in place arrangements for planning, organisation, control, monitoring and review of health and safety measures.
  - Employer to obtain competent health and safety assistance.
  - Employer to provide information on health and safety matters to employees.

# Health Protection (Coronavirus, Restrictions) (England) Regulations 2020

- Closes restaurants, canteens, cafes, bars and public houses during the emergency period – limited exceptions.
- Closes other businesses including gyms, sports courts, soft play areas, etc.
- Restrictions on movement – no person may leave the place where they live without reasonable excuse, including:
  - to travel for the purposes of work where it is not reasonably possible for that person to work from home.

- [www.gov.uk/coronavirus](https://www.gov.uk/coronavirus)
- Following guidance is evidence that you are reducing the risk to as low as reasonably practicable.

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- [www.hse.gov.uk/news/coronavirus.htm](https://www.hse.gov.uk/news/coronavirus.htm)

- Coronavirus Regulations require people to work from home where reasonably possible
- No requirement for DSE assessment for temporary working from home
- Risk assessment. <https://www.iosh.com/media/1507/iosh-home-office-mobile-office-full-report-2014.pdf>
- Mental health



- People who are very vulnerable (e.g. solid organ donor recipients, people with specific cancers, people with severe respiratory conditions, etc.) should rigorously follow social distancing advice.
  - Received letter advising them to stay at home at all times for 12 weeks (“shielding”)
- People who are increased risk (e.g. aged 70 or over, have underlying health conditions or are pregnant) should be particularly stringent in observing social distancing measures.

# Taking on new employees

- May be needed if expanding production or making new products
- More people looking for work?
- Competence – especially for those in safety-critical work
- Training, instruction and supervision
  - Absences?
- PPE
- Work equipment
- Do contractors have own H&S management systems in place?
  - Due diligence

# Post-Grenfell fire safety update

# Rob Biddlecombe



- 14 June 2017.
  - 72 deaths – largest loss of life in a residential property since Second World War
  - 70 injured
  - Devastated local community
  - Wider loss of confidence in high rise housing

- Independent review looking at current Building Regulations and fire safety, particular focus on high-rise residential buildings (separate to public inquiry).
- Final report published May 2018 – current system for ensuring fire safety in high rise and complex buildings is not fit for purpose.
- Recommendations include:
  - New regulatory framework focussed on multi-occupancy higher risk residential buildings (10 storeys or more).
  - New Joint Competent Authority to oversee better management of safety risks in HRRBs.
  - Clear and identifiable dutyholder with responsibility for safety of entire building.
  - Dutyholder to present safety case to JCA regularly.
  - Mandatory incident reporting mechanism for dutyholders with safety concerns.
  - Clearer rights and obligations for residents to maintain the fire safety of individual dwellings (working with dutyholder).
  - Power for JCA to act as regulator for fire and structural safety of whole building and fire dutyholders.

- In force from December 2018.
- Ban on the use of combustible material in the external walls of buildings over 18m in height which contain:
  - One or more dwellings;
  - An institution (e.g. care home); or
  - A room used for residential purposes (does not include a room in a hostel, hotel or boarding house).
- Covers apartments, hospitals, care homes, dormitories in boarding schools, sheltered housing and student accommodation.
- Ban covers all of the material in the walls, not just the cladding.
- Materials used now need to be Euro Class A2-s1, D0 or Euro Class A1.
- Does not apply to:
  - buildings where building work started before or within 2 months of 21 December 2018; or
  - new hotels, hostels, and boarding houses which are over 18 metres in height.



- May 2018 – UK government committed to £400m to pay for councils and housing associations to replace aluminium composite material cladding in 158 tower blocks owned by local authorities and social housing providers.
- May 2019 – Further £200m allocated towards the cost of removing and replacing ACM cladding from 170 privately owned tower blocks.
- Quotations for remediation have typically been in the £4m-£5m range and the £200m averages out at about £1.2m per building - shortfall.
- Also, funds not available for combustible non-ACM cladding.
- Potential for landlords to recover costs from tenants as part of service charge:
  - Rectifying inherent defect?
  - Complying with laws – Regulatory Reform (Fire Safety) Order 2005.

- Led by Sir Martin Moore-Bick
- Phase 1 Report (focusing on the events on the night of 14 June 2017) published January 2020 and recommended new legal duties on owners and managers of high-rise residential buildings to:
  - inform local fire and rescue services about the design and construction of external walls and about any material changes made to them;
  - provide fire services with up-to-date building plans;
  - draw up and test evacuation plans;
  - test any lift systems designed for use by firefighters on monthly basis and report test results to the fire service;
  - issue all residents of their buildings with easy-to-understand fire safety instructions;
  - fit alarm systems that allow the emergency services to issue an evacuation warning to all or part of the building; and
  - conduct three-monthly inspections of fire doors.
- Phase 2 now underway (focusing on design and construction of building, refurbishment, warnings from local community, local authority response, etc.)

- Immediate establishment of the Building Safety Regulator.
  - Based on Hackitt recommendation
  - Will oversee the design and management of buildings, with focus on higher-risk buildings.
  - Will have a range of sanctions and enforcement powers (inc. prosecutions).
  - To begin in 'shadow' form until established under legislation (Building Safety Bill).
- Updated guidance for building owners on building safety
  - Issued by Independent Expert Advisory Panel.
  - Measures cover the use of aluminium composite material (ACM) cladding, external wall systems and fire doors.

- Consultation on extending the combustible cladding ban – ends April 2020.
  - Including hotels, hostels and boarding houses within the scope of the ban.
  - Lowering the height threshold of the ban from 18 to 11 metres above ground level.
  - Banning the use of metal composite materials with a polyethylene core in and on external walls and in specified attachments in all buildings, regardless of height.
  - Extending the ban to include solar shading products, including but not limited to blinds and shutters.
- Information about the forthcoming Fire Safety Bill.
  - Clarify that building owners or managers of multi-occupied residential buildings of any height are required to consider fully and mitigate the fire safety risks of any external walls and front doors to individual flats.
  - Affirm Fire and Rescue Services' power to enforce locally against building owners who have not remediated unsafe ACM cladding.

- Steps to ensure that remedial works to existing buildings are not further delayed.
  - To "name and shame" building owners who have not started removing unsafe ACM cladding from their buildings.
  - Work with local authorities to support them in their enforcement options where there is no clear plan for remediation.
- Call for evidence to define the scope of future research on fire safety risk in buildings.
- A promise to clarify proposals for lowering the height threshold for sprinkler requirements in new buildings.
  - From 30m to 18m in height.

# France Telecom (FT): How NOT to manage a corporate restructuring exercise from an employee well-being perspective

# Gary Lewis





- FT was privatized in 2004.
- Prior to the privatization of FT its employees had enjoyed quasi-civil servant status, which meant that they had the 'job for life' guarantee afforded to state sector employees.
- FT experienced a wave of suicides between 2007 – 2010 following the launch of an ambitious restructuring plan.

## The Restructuring Plan:

- Known as the “NExT plan”
- To cut 22,000 jobs (20% of the total workforce) and
- Re-deploy/re-locate a further 10,000 employees
- Over a three year period, commencing 2006
- Former CEO is alleged to have told managers in 2006 that he would “get people to leave one way or another, either through the window or the door”
- This was against the backdrop of a struggling business model as customers were moving away from fixed phone line services to mobile and internet services

- Dozens of suicides happened during the restructuring exercise
- By 2009 – 35 employees had committed suicide

- One employee who did jump out of a fifth floor window, in front of her colleagues, left a suicide note expressing deep unhappiness at work.
- A technician left a letter accusing his bosses of “management by terror” and concluded “I am committing suicide because of FT. There is no other cause”.
- An employee wrote to senior management complaining of an endemic problem, saying “Nothing is being done to face up to it: Suicide remains the only solution”.
- An employee committed suicide by setting himself on fire in an FT car park on arrival at work.
- Another technician attempted suicide by stabbing himself in the stomach during a team meeting, when it was announced that he was being transferred to a call centre.

- In 2010 a report by Labour Inspectors said that the management used “pathogenic” methods, such as forcing people into new jobs in distant towns and giving them unattainable performance targets.
- This caused national outrage over the culture of the business, against the backdrop of the number of suicides involving FT employees.

- This culminated in a criminal trial in 2019 lasting 3 months.
- The trial focused on 39 cases between 2006 -2009, comprised of :
  - 19 suicides
  - 12 suicide attempts
  - 8 cases of serious depression

*Note:* Other employee suicides could not be linked directly and solely with their work



## The Defendants and the Charges:

- Former CEO (Didier Lombard) – Moral Harassment – French term for *bullying*
- Former Deputy CEO (Louis-Pierre Wenes) - Moral Harassment
- Former Human Resources Director (Olivier Barberot) - Moral Harassment
- The Company – since rebranded as Orange – Institutional Moral Harassment
- Four executives – Complicity in Moral Harassment

## At the trial:

- Lombard (former CEO) denied that senior management bore any responsibility for the deaths.
- He initially denied having told managers he would “get people to leave one way or the other, either through the window or the door” - But later said he “made a blunder” by making the statement.
- He admitted to once saying there was a “a fashion for suicide in the business”.
- He maintained “The transformations a business has to go through aren’t pleasant, that’s just the way it is, there’s nothing I could have done”

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## Conclusion of trial:

Judges upheld the full prosecution argument that FT had embarked upon a plan to humiliate staff into leaving the Company as a way of bypassing France's strong job protection laws after the state monopoly was privatized.

## The Court found:

- The means chosen to reach 22,000 departures resembled a “*forced march*” and were “*illicit*”.
- Claims that departures were voluntary were “*simply for show*”.
- The 3 senior former bosses had put “*pressure on managers*” who “*relayed that pressure*” to their teams.
- The plan created a “*stress-inducing climate*”
- The result was a “*concerted plan to degrade employees’ working conditions in order to accelerate their departure*”.

## The sentences:

- The three former senior bosses – One year custodial sentence, with 8 months suspended and a fine of 15,000 Euros
- The Company – 75,000 Euros (maximum fine)
- The four less senior executives – Four months custodial sentence – suspended + 5,000 Euros fine

**Note :** Under French law – the convicted executives are unlikely to spend time in prison because sentences of 12 months or less are routinely changed to other penalties, such as community service and “house arrest” enforced by electronic ‘tagging’

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## Appeals:

- The individual defendants have lodged appeals against their convictions which will result in an automatic re-trial.
- The Company is not appealing the conviction or sentence



## Could this happen in the UK?

- Section 2 HSWA would apply – general duty – qualified by reasonable practicability - with reverse burden of proof
- HSE has identified work-related stress and related mental health issues as part of its Health and Work Strategy.
- HSE advocates effective management of work related stress by Management Standards Approach. In essence a conventional risk assessment approach, which is a bit “one size fits all” and doesn’t really lend itself to identifying and controlling a dynamic risk.
- Regulation 3 – Management of Health and Safety at Work Regulations 1999 – Risk assessment
- Regulation 5 - Management of Health and Safety at Work Regulations 1999 – Arrangements - for the effective .....*monitoring and review* of the preventative and protective measures
- An effective monitoring and review process would be expected to identify any particular trends (high incidence of suicides in workforce) and implement measures to combat the issue.
- Identifying a particular trend and taking no or demonstrably inadequate steps to address the issue could constitute breach of Section 2 HSWA by the employer.

**Note :** Causation is not a component of an offence under S2 HSWA. If the breach could be shown to have caused the death(s) then that may result in an increase on the level of fine (*Whirlpool*)

- The results of the monitoring and review function would/should form the basis of management information submitted to senior management to enable them to satisfy themselves that the Health and Safety Management System is effective in eliminating or controlling foreseeable risks arising from the work activities conducted by the Employer.
- If the Company commits an offence under Section 2 HSWA – failure to manage stress in the workplace, so far as reasonably practicable – Directors and Managers can commit the same offence by virtue of their Consent, Connivance or neglect – Section 37 HSWA.

- Gross Negligence Manslaughter (individual offence) requires “Gross Negligence” and causation of death (although causation threshold is low). May be a difficult proposition given the lack of proximity of director or manager (in a large company) to the breach.
- Corporate Manslaughter (corporate offence) requires “Gross Negligence” at Senior Management Level and causation of death (again the causation threshold is low). Rarely used in a conventional setting, so unlikely to be deployed in a case involving suicides alleged to be linked to failure to manage stress in the workplace.

**Note :** manslaughter cases are investigated by the Police and prosecuted by CPS

*Note:* Suicides are excluded from reporting under RIDDOR

- All deaths to workers and non-workers, **with the exception of suicides**, must be reported if they arise from a work-related accident, including an act of physical violence to a worker.
- How would a regulator even get to know of a suicide that may be linked to a failure to manage stress in the workplace ?
- Via the Coroner who is under a duty to consider a Report to Prevent Future Deaths at the conclusion of the Inquest. Query would a number of Coroners in different geographical areas identify a trend attributable to a Company ?
- Would the HSE be interested, given that they have excluded suicides from RIDDOR reporting.
- Would the police be interested, given the evidential difficulties associated with manslaughter prosecutions

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## Conclusion:

- The mechanism for a criminal prosecution of a company and/or individuals for failing to manage work-related stress is there.
- Is there the appetite on the part of regulators ? Seemingly not.

# The duty of candour – what is it and when does it apply?

# Bethany Thompson



- 
- What the duty of candour is
  - How the duty of candour has evolved
  - How it is evolving/might it evolve further

What the duty of candour is



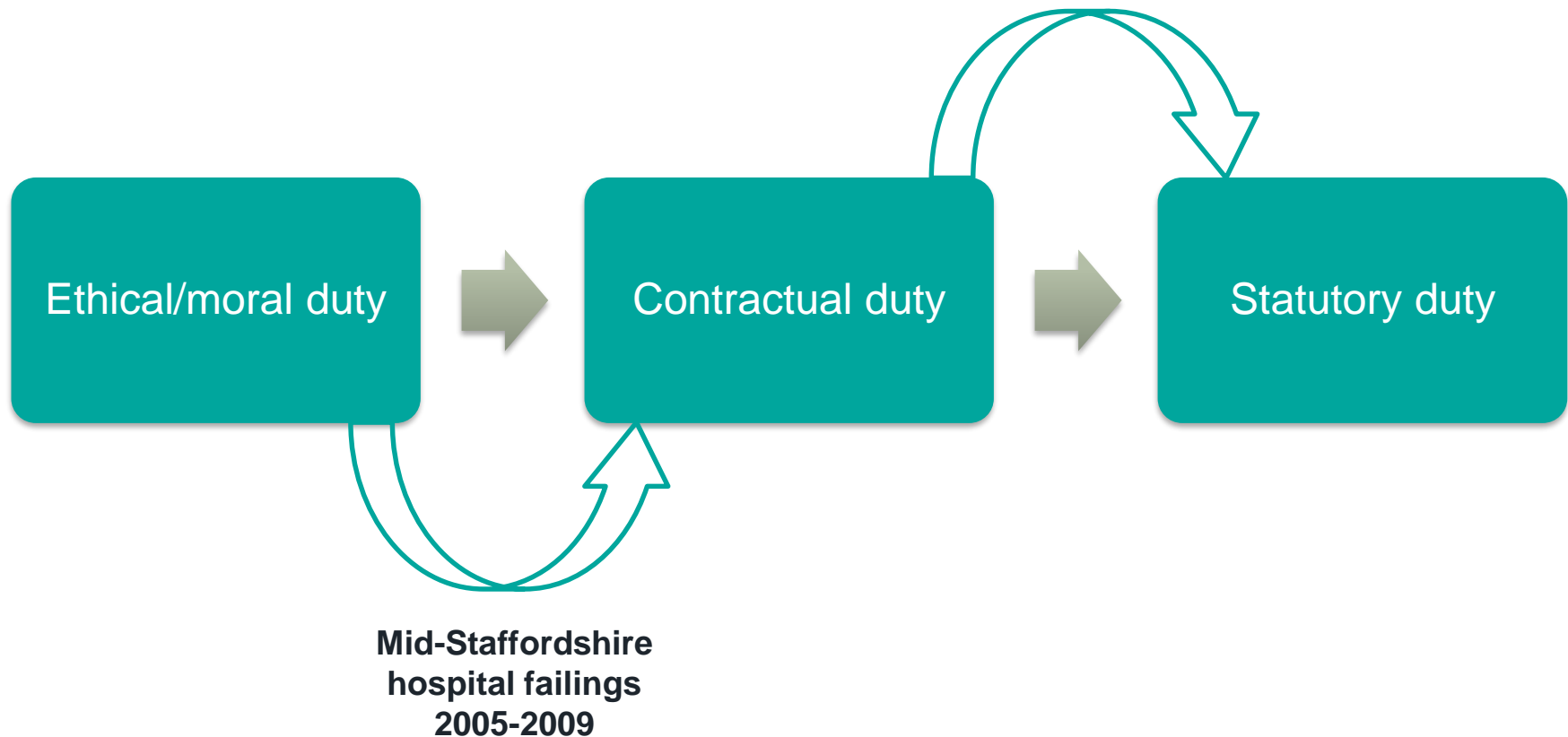
**“The quality of being open and honest;  
frankness.”**

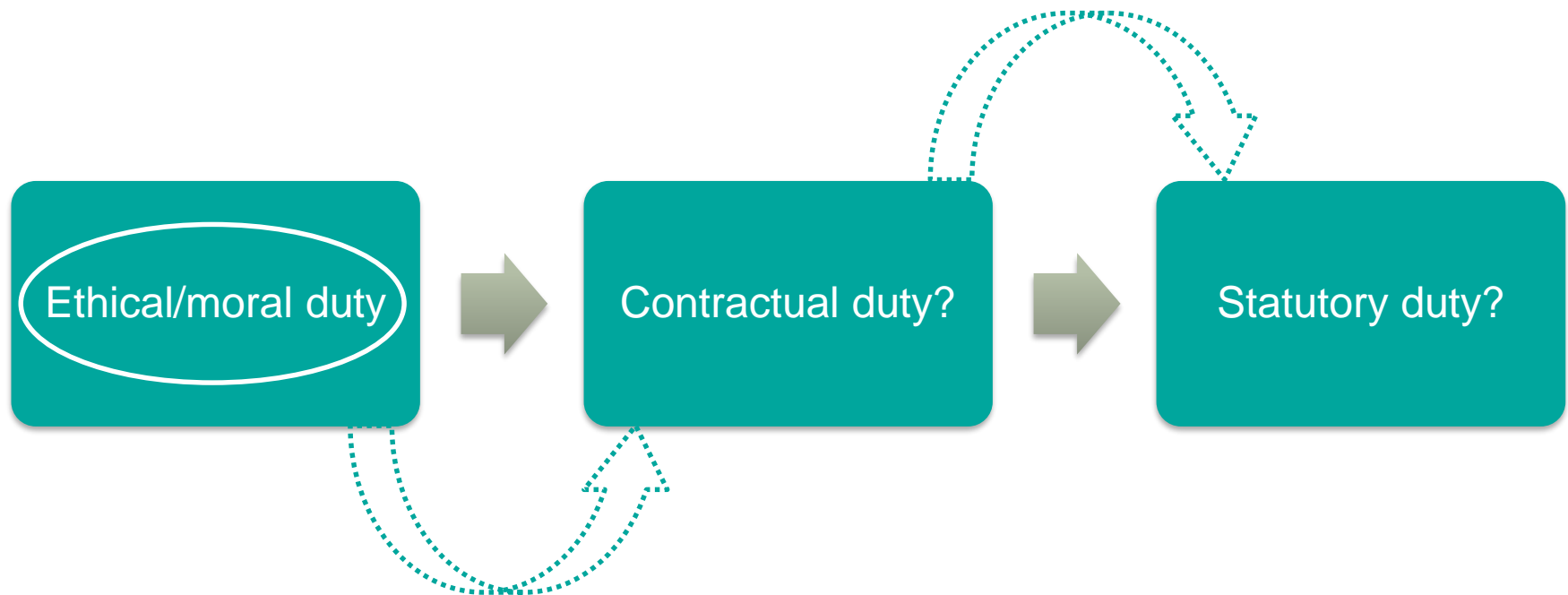
- Public bodies
- No disclosure duty
- True and comprehensive account of decision-making
- Sufficient search for material and disclosure

- Overall engagement
- Disclosure
  - Coroners and Justice Act 2009 sch.5
  - Inquiries Act 2005 s.21
- Statements
  - E.g. statement of changes, position statements

## Evolution of the duty of candour

Robert Francis QC Report  
2013





In adopting this charter I commit to ensuring that the [organisation] **learns the lessons of the Hillsborough disaster and its aftermath**, so that the perspective of the bereaved families is not lost. I commit to [organisation] becoming an organisation which strives to:

- 1) In the event of a public tragedy, **activate its emergency plan** and **deploy its resources** to rescue victims, to support the bereaved and to protect the vulnerable.
- 2) Place the **public interest above our own reputation**.
- 3) Approach forms of public scrutiny – including public inquiries and inquests – with **candour, in an open, honest and transparent way**, making **full disclosure** of relevant documents, material and facts. Our objective is to assist the **search for the truth**. We accept that we should **learn from the findings of external scrutiny and from past mistakes**.
- 4) **Avoid seeking to defend the indefensible** or to dismiss or disparage those who may have suffered where we have fallen short.
- 5) Ensure all members of **staff treat members of the public** and each other with **mutual respect** and with **courtesy**. Where we fall short, we should apologise straightforwardly and genuinely.
- 6) Recognise that we are **accountable and open to challenge**. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We **do not knowingly mislead** the public or the media.

- Increasing importance
  - Proceedings' expectation
  - Public's expectation
  - Future legal obligation?
  
- Tips on meeting the duty of candour
  - Engagement
  - Document management system
  - Lessons learned

# Recent fines and sentencing update

# Gary Lewis





**HSE**

**v**

**Bupa Care Homes (BNH) Limited**

**Appeal against sentence**

**Court of Appeal - 11 October 2019**

Prosecution by HSE following death of Kenneth Ibbetson (aged 84) from Legionnaire's disease in June 2015.

- Mr Ibbetson was resident at a care home owned and operated by Bupa (BNH)
- Breach - Section 3 HSWA
- Prosecution case was that water systems at the care home were not maintained in a safe manner (so as to eliminate or reduce the risk of bacteria developing), so far as reasonably practicable
- Prosecution pointed to multiple systemic maintenance failures over a number of years which culminated in the water systems posing a risk of Legionnaire's disease developing at the care home

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BUPA (BNH) engaged the services of specialist contractors, *Advance Environmental Ltd*, to help it control the risk.

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## Corporate structure

Bupa (BNH) is a wholly owned subsidiary of its Parent Company - BUPA.

HSE issued summonses against:

- BUPA [Parent] - First Defendant (D1) *[VLO for the purposes of the Guideline]*, and
- BUPA (BNH) [Subsidiary] - Second Defendant (D2) *[A large organization for the purposes of the Guideline]*.

HSE case against both defendants:

- The immediate operational failures were those of D2 (subsidiary)
- D2 operated under the instruction of D1 (parent) and was subject to supervision and monitoring of D1
- It was the responsibility of D1 to *identify and correct deficiencies* in the control of Legionella by D2
- Public interest requires the prosecution of D1

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## Defendants pleas

- D2 Pleads guilty at first opportunity - on a basis to be agreed, (if possible)
- D1 pleads not guilty and was committed to the Crown Court for trial

HSE response to the pleas:

- To invite D1 to change its plea and for both Defendants to accept the way the prosecution case was put
- D2's basis of plea was not accepted



Defendants submit to HSE:

- Failings to control Legionella risk at the care home could properly be reflected by sentencing of D2. *If D1 pleads guilty, D1's accounts would be considered as part of the sentencing exercise of D1*
- The financial position of D1 could be taken into account at the sentencing of D2, if the criteria set out in the Guideline was made out
- *The implication from the Defendants' submissions is that the HSE were looking at D1 as a substantive defendant (responsible in part for the breach) and in terms of the extent to which it would be artificial to ignore the financial resources of D1 in terms of the sentencing exercise*

Further submissions by HSE:

If a revised basis of plea is to prompt a re-assessment of the public interest test against D1 the basis of plea of D2 would have to reflect the seriousness of the offence and D1's involvement in the offence committed by D2.

**Note:** *This suggests that the HSE were thinking that by getting D2 to acknowledge the involvement of D1, in terms of commission the offence, in its basis of plea it would make D1's financial resources available when sentencing D2.*

D2's revised basis of plea:

- The sentencing court is entitled to take into account and reflect how this failure by BUPA BNH (D2) was part of a failure to fully implement a system for centralized oversight of Legionella control measures within care services. *This is nicely 'bland' in terms of D1's involvement in the breach*
- It is accepted that the sentencing court can properly reflect the economic realities of BUPA BNH (D2), i.e. reflect how it is a wholly owned subsidiary with its ultimate parent owner being D1. *This amounts to nothing more than a recital of the Guideline*

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D2's revised basis of plea does the trick!

HSE discontinue the case against D1 (parent), making it clear that the decision followed the concession that the Parent's financial position could be taken into account at D2's sentencing hearing.

Prior to sentence there was a Newton Hearing to determine:

- The extent of the Defendant's (D2) failings
- The extent to which the breach could be held to have caused the death of Mr Ibbetson *[If breach causative of death it may result in upward adjustment - Whirlpool]*

## Sentencing by the Judge:

- No dispute that Mr Ibbetson contracted Legionnaire's disease at the home
- Source of bacteria was likely to have been an aerosol from the hot tap in his room, which was sampled the day after his death and showed readings of Legionella far in excess of safe limits

## Sentencing by the Judge - Culpability:

- HSE contend for High culpability - Defendant fell far short of the appropriate standard by allowing breaches to subsist over a long period of time
- Defendant contends for Medium culpability - Systems were in place but they were not sufficiently adhered to

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## Sentencing by the Judge - Culpability continued:

- Risk assessment in 2012 had noted that steps being taken to control Legionella risk were insufficient and further steps were required
- The system to control Legionella risk had devolved responsibility down to untrained persons, namely the manager of the home who was supported by no permanent or trained maintenance man
- Records in 2014 had been falsified and the maintenance man was dismissed. His replacement was untrained
- Defendant conducted risk assessments bi-annually - no systematic approach to remedying deficiencies identified in the risk assessments.
- Failure to flush the system regularly
- Failure to carry out temperature checks



## Sentencing by the Judge - Culpability continued:

- Overall the Judge found that numerous problems had been identified, many of which were risk factors for the proliferation of Legionella bacteria and few, if any, were adequately tackled
- Refurbishment of the Home in 2014/15 did not address any of the plumbing issues
- No flushing and disinfection took place after the refurbishment work had been completed and the Defendant failed to obtain the appropriate certification that this had been done
- February 2015 - Advance Environmental do annual check:
  - Noted vulnerable population
  - Low water flow and return temperatures (both identified in 2014 risk assessment) had not been dealt with
  - Report also noted a range of other issues

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## Sentencing by the Judge - Culpability continued:

- Judge determines Culpability as **High**

## Sentencing by the Judge - Harm

- Seriousness of harm *risked* was agreed at Level A
- Likelihood of Level A arising – Having considered statistical evidence about mortality rates from Legionnaire's disease she determined Likelihood of harm as **Low**
- Harm Category 3

## Sentencing by the Judge - Harm

- Harm Stage 2
- Whether the offence exposed a number of people to risk of harm - *Judge decides a number of employees and residents were exposed to risk of harm on basis that a number of outlets had tested positive at the Home*
- Whether the offence was a significant cause of actual harm - *Judge found that most likely cause of proliferation of the bacteria at the home was the failure to flush and disinfect the pipes after the refurbishment work. The Defendant had not obtained the necessary Certificate **but that was not, of itself, a significant cause of Mr Ibbetson's death***
- As a result of positive answer to question 1 - Judge decides to move up a harm category to Harm Category 2

## Sentencing by the Judge

- Defendant's turnover was £83m (average) so Large Organisation for the purposes of the Guideline
- High culpability + Harm Category 2
- Starting point of £1.1m
- Category Range of £550k > 2.9m

## Sentencing by the Judge

- Judge says that given the assessment of culpability and harm, combined with Defendant's turnover, there is good reason to move upwards from the starting point within the category range.
- "Taking account of all the relevant factors and my conclusions on culpability and harm, at the conclusion of Step 2, I reach a fine of £2.25m"

## Sentencing by the Judge

- Step 3 - Adjustment of fine set at Step 2 (based purely on turnover)
- She took account of the concession in the revised basis of plea re the financial position of the Parent Company (D1)
- She then referred to **Group revenue** in the region of £11.5b (average), with profits of £383m (average)
- "This is a profitable organization, both BUPA as a whole and this particular subsidiary"
- "BUPA as a whole *[not the Defendant being sentenced]* is an enormous organization and has huge revenues. In order to meet the aims of sentencing and to reflect all of these considerations, I consider it proper at Step 3 to elevate the Starting Point from £2.25m to £4.5m which, in my view, meets the justice of all these points"
- She then reduced the penalty by 1/3 to £3m to reflect the Defendant's (D2) early guilty plea

## Defendant's Grounds of Appeal:

- Ground 1 - Increasing the Starting Point at Step 2 from £1.1m > £2.25 - the Judge had engaged in double counting because she considered Culpability and Harm, which had already been taken into account at Step 1
- Ground 2 - At Step 3 the Judge applied an upward adjustment to the level of fine (£2.25 > 4.5m) on the basis of consideration of the Parent Company's financial position



## Court of Appeal

### Ground 1

- Do not accept that consideration of culpability and harm should be excluded from Step 2. If there are a multiple of culpability factors present, as opposed to one, that can be regarded as a matter capable of increasing the Starting Point within the Category Range.
- Judge found a number of residents and employees were exposed to risk.
- In our judgment, this was a very bad case with ***all*** of the factors in the High Culpability bracket being present (page 4 of the Guideline).
- Those matters justified an increase above the Starting Point of £1.1m.

### Ground 1 failed

## Court of Appeal

### Ground 2

- The Guideline phrase ‘economic realities’ cannot be extended to mean that the Parent’s resources belong to the Subsidiary simply in order to justify a large increase in the level of fine at Step 3.
- If it is generally wrong to take into account the Parent’s turnover so as to increase the Subsidiary’s turnover at Step 2, then it is wrong to take into account to increase the level of fine at Step 3.
- The uplift at Step 3 was wrong in principle.
- The fine before discount should have been £2.25m.
- Applying 1/3 discount for the early guilty plea = £1.5m

### Ground 2 succeeds

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## Court of Appeal

Fine of £3m quashed and substituted with a fine of £1.5m.

# Questions?



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