Neutral Citation No: [2024] NICC 26	*Ref:* **[2024]NICC26**
	ICOS No: **24/036030**
*Judgment: approved by the court for handing down (subject to editorial corrections)**	*Delivered:* **17/10/2024**

IN THE CROWN COURT OF NORTHERN IRELAND

_____

THE KING

v

GLAS-SEAL (NI) LTD

_____

SENTENCING REMARKS

_____

MILLER HHJ

Charges

[1] The defendant pleaded guilty on arraignment on 1 October 2024 to **Count 1** on the indictment. This plea was on the basis that it also encompassed the breaches outlined in the other counts. Following this plea, the remaining counts were left on the books. The Company therefore falls to be sentenced on the charge of Failing to Ensure the Health and Safety of Employees, contrary to Article 4(1) of the Health and Safety at Work (NI) Order 1978, arising on 19 May 2022.

Facts

[2] This case relates to an incident on 19 May 2022 at the warehouse of the defendant company, Glas-Seal NI Limited in Ballynahinch. The deceased, Mr Terence Kilmartin who started working for the company in 1980, sustained fatal injuries when he was struck by an industrial pack of glass, known as an "end-cap", whilst carrying out an unloading activity on site.

[3] Mr Kilmartin was in the warehouse with employee, Donald Walsh and a Tipperary Glass delivery driver, Michael Fogherty, unloading end caps from the delivery lorry when the accident occurred. CCTV shows Mr Kilmartin performing several unloading operations, using an overhead gantry crane to move end caps from the lorry onto custom A-Frame storage stillages.

[4] After one of these unloading operations, CCTV, which I have viewed, shows Mr Kilmartin turn his back to the A-Frame storage stillage on which an end cap was

just placed and moments later the end cap falls forward striking Mr Kilmartin knocking him to the ground.

[5] The end cap that struck Mr Kilmartin was the sixth that was unloaded that day each estimated to weigh 2.2 tonnes. Mr Walsh and Mr Fogherty were both in the immediate vicinity and instantly rushed to help Mr Kilmartin and raise the alarm. Mr Kilmartin was taken to the Royal Victoria Hospital with head injuries and a bleed on the brain where he died from his injuries four days later 23 May 2022.

[6] The process of unloading the end caps at the time of the incident involved the use of an overhead gantry crane with a dual wire sling attachment. The crane was brought over the delivery lorry and the wire sling lowered. Mr Fogherty attached the wire slings to the two custom wooden lugs or lifting points built into the wooden end-cap. Then Mr Kilmartin used a wireless pendant or remote control to operate the overhead crane and remove the end cap from the lorry towards the storage stillages.

[7] The CCTV does not cover the A-Frame and so the end cap cannot be seen once it is placed on the storage stillage. In the seconds leading up to the incident Mr Kilmartin is seen looking down at the wireless remote control and the crane moves from left to right. It is possible that this movement was caused by Mr Kilmartin when using the control. The end cap subsequently falls forward and strikes Mr Kilmartin knocking him to the floor.

[8] HSENI served a Prohibition Notice given their initial findings of there being no safe system of work in place for the lifting and moving of end caps. This was not appealed and post incident the company have provided HSENI with an updated Safe System of Work, Risk Assessment and Lifting Plan with additional safety control measures.

[9] The investigation considered the circumstances surrounding the final placement of the end cap on the A-Frame and removal of any lifting accessories after the load had been placed onto the stillage rather than on the principal lifting operation.

[10] HSENI instructed the Glass and Glazing Federation's Technical Department to look at the glass in question. They concluded that the packaging was fit for purpose with no evidence of any defect that could have contributed to the accident.

[11] An inspection of the A-Frame revealed no evidence of any defect. The leg extenders provide an extended storage area on which to place additional end caps. At the time of the incident there were only two end caps that had been placed on the A-Frame in question and it is therefore unlikely that the A-Frame leg extenders played a significant role in the accident, however their involvement cannot be completely ruled out.

[12] The investigation looked at whether an unknown external force would have caused the end cap to move in the way that it did, but it was concluded that this was

unlikely for several reasons including the fact that the other end cap that was already on the A-Frame did not move.

[13] In relation to the crane, it was confirmed that there were Lifting Operation and Lifting Equipment Regulations certificates in place at the time and there was no evidence to suggest that the lifting equipment failed.

[14] The following are the possible scenarios suggested by HSENI as the cause for the end cap to fall in the manner that it did:

(i) The end cap was struck from behind with the lifting equipment after Mr Kilmartin moved the crane forward with the remote device. This is unlikely to have created the force required.

(ii) The wire sling was not cleared from the end cap after it was placed on the A-Frame causing the sling to snag on the wooden lifting lug or another section of the end cap. The overhead gantry crane had the ability to pull the load forward and off the storage A-Frame.

(iii) An unexplained force occurred from behind the end cap causing it to fall forward.

[15] Having completed their investigation HSENI concluded that a wire sling was most likely still located behind the end cap immediately prior to the accident. HSENI hypothesis therefore is that the most likely scenario is that at ***sub-para (ii)*** above. It is noted that Mr Fogarty indicates that "both slings were in front of the end cap at this stage, in the middle of the frame. Clear of the lifting lugs." This is not supported by the CCTV.

[16] It appears that Mr Walsh's practice was to use a step ladder to remove the sling from his side of the end cap, but Mr Kilmartin used the crane to unhook the other sling by moving it sideways. For some reason the sling appears to have snagged on the right corner of the end cap causing it to fall when the crane moved forward. **There is no direction in the Safe System of Work documentation in relation to ensuring that both parts of the wire sling are clear of the end cap before the crane is moved forward.**

[17] The company were working to a guidance document which relates to the general principles of lifting end cap packs. **Whilst providing a general outline regarding the principles of how packs of sheets can be lifted, every employer is required to conduct a suitable and sufficient risk assessment and develop a safe system of work.**

System of work

[18] The company produced a one-page document entitled **Unloading Glass Packs from Delivery Lorries** with six numbered instructions prepared in house in 2016.

[19] The safe system of work did not include any detail in relation to the following:

(i) Specific instructions regarding the safety critical working methods such as positioning and attachment of lifting equipment, the placement and removal of wire slings on end cap wooden lugs and the precautions to take when doing so.

(ii) Specific instructions regarding lifting and travelling with the load including safe positioning of the operator and others before, during and after handling of the load.

[20] It is important to note that this crane was operated by a wireless remote control which would have allowed the operator to stand clear of the load and danger zone during the lifting moving operations.

Risk assessment

[21] The company produced a documented pre-incident risk assessment called **Yard Area and Loading Bay – Unloading Delivery Vehicles.** This was a two-page document which was last reviewed in-house in 2018 and signed by Mr Kilmartin in 2021.

[22] The same issues as highlighted in the System of Work document apply in equal measure to this risk assessment.

Training

[23] Mr Kilmartin's training file was provided to the investigators. He received one day's training entitled **"Basic Awareness on Overhead Gantry Cranes"** in 2002. There was no other formal training internal or external in relation to cranes in the 20 years between that course and the accident.

[24] There was some familiarisation training in 2022 when the latest crane was installed but this was not formal training and there was no record kept.

Interview

[25] At interview the company Director, Michael Ravey made several admissions accepting that the deceased could and should have been standing to the side during the task of moving the glass and that their existing safe system of work did not include a direction to remain outside of the range before and during the manoeuvre of glass, especially given that the control pendant was wireless. During their internal investigation they also concluded that that the SSOW (Safe System of Work) was not detailed enough.

[26] He also accepted that risks and control measures associated with the movement of glass from lorry to A-Frame were absent from the Risk Assessment. Control measures in relation to operatives positioning and instruction on fixing and removal of slings to wooden lugs during handling were not included.

[27] In relation to the training of the deceased he confirmed that there was no internal or external refresher training provided in relation to the crane in almost 20 years.

Basis of Plea

[28] The defendant pleads guilty on the basis that it failed to ensure, so far as was reasonably practicable, the safety of its employee Terry Kilmartin in:

(i) Failing to ensure that he was provided with suitable and sufficient training in relation to the safe use of overhead cranes.

(ii) Failing to identify and assess the risk of the wire ropes (used to secure the end cap while being moved from the delivery vehicle to the A-Frame) snagging on the end cap when within the A-Frame and dislodging it from the A-Frame when the overhead crane was being moved.

(iii) Failing to instruct employees, including Terry Kilmartin, and non-employees to stand in a safe location, to the side of the end cap frame, until such time as he could be satisfied visually that the wire ropes supporting the frame while it was being positioned within the A-Frame were free from the end cap and not liable to snag when the overhead crane was being moved.

General

[29] The court has received and read statements from Mr Kilmartin's wife, son and daughter. Out of respect for their wishes I shall not read extracts from either statement, but it can be understood that he was a much-loved family man and that his loss continues to have a devastating impact upon those closest to him. Nothing this court can do or say can undo what has been done or bring him back to his family, but I extend my sympathy and condolences to each one in their loss.

[30] The defendant company has no previous convictions.

Defence submissions

[31] Mr O'Donoghue KC (appearing with Mr J P Shields) stressed at the outset, the company's profound regret and sincere remorse at the part it played in Mr Kilmartin's death. He had worked for Glas-Seal Ltd for almost 43 years, joining in 1980 and he was a much-valued employee and colleague in what is a relatively small enterprise, with strong local and community roots.

[32] The plea in mitigation needs to be understood in the context of the company's acceptance of its responsibility for this tragic accident. That plea was entered at arraignment and against a background where there had been a full level of co-operation and engagement with HSENI in the investigation of this incident.

[33] In this regard, Mr O'Donoghue drew attention to how at the initial interview Michael Ravey, on behalf of the business, set out the facts that were known to him and was open and frank about the entire incident. The company undertook its own full investigation into the cause of the accident and the accident report was accepted and adopted by the HSE(NI). The company wanted to understand what went wrong and how to ensure lessons were learned and any necessary remedial steps taken.

[34] The impression that emerges from the conclusions to the reports and statements on the file, is not of a company that wilfully disregarded health and safety considerations or sought to cut corners in that regard. Indeed, the picture that emerges is of a company that valued its employees and sought to instil a sense of cooperation and community at all levels throughout the business. Mr Kilmartin was very much at the core of that team and was clearly one of the most experienced and trusted employees in the firm.

[35] The operation he was engaged in on the day of his death was one he had carried out on countless occasions over many years. There had never previously been an issue, still less a serious mishap in the process of unloading the endcaps and this was carried out in compliance with the guidance document from the Glass and Glazing Federation. A new Abus 5 tonne overhead crane had been installed in January 2022 in the incoming goods area which had a handheld portable controller, making it easier for the crane operator to manage the operation.

[36] The company accepts that Mr Kilmartin had not been provided with recent refresher training on the lifting of end caps, nor had he been issued with specific directions and instructions in this regard. Whilst accepting this responsibility for these deficits, the company emphasised that Mr Kilmartin was regarded as the most competent and experienced member of staff it employed when it came to lifting operations. In a very specialised industry, he would have had more experience and knowledge of lifting endcaps than almost anyone within the industry, at least within Ireland.

[37] The company concedes that it perhaps took Mr Kilmartin's level of expertise for granted, and, when considering his position as the trainer for other staff, it should have also ensured that he had refresher training himself and that the basics were re-enforced. This, the court accepts addresses the core failure in this case. The company assumed based on Mr Kilmartin's experience rather than making an objective analysis of foreseeable risk and ensuring that an appropriate and regular level of training was implemented. In terms the company was guilty of an unintended complacency. The fact that the process had been carried out without incident for several years, was

allowed to cloud judgement as to the serious and indeed, as this case proved, fatal consequences that could ensue when something went catastrophically wrong.

Company background

[38] Mr O'Donoghue addressed the court on the history of the company since it was established over 50 years ago. As previously noted, it is intimately associated with its base in Ballynahinch and the many testimonials from local sports clubs, charities, suppliers and contractors attest to the significant contribution the company has brought and continues to bring to the local community in terms of employment opportunities for the 68 workers together with supporting worthy causes in the local area.

[39] The company, like many others, has weathered the storms of recession in the early part of this century and more recently the impact of the Covid pandemic. It went into administration in 2012 and was then the subject of a management buy-out. Since 2019 the current directors, who were part of that management team, have jointly owned and managed the company.

[40] Glas-Seal has a reputation within the industry for technical competence, product quality and regulatory compliance and was first awarded the ISO 9001 British Standard in 2005 and has retained this standard since.

[41] Mr Kilmartin's death was a truly awful reminder that for a company that prided itself in the care of its employees that, even with the best of intentions and efforts, even with the level of experience and understanding of glass that Mr Kilmartin had, sometimes things go unexpectedly and terribly wrong. His death was, to quote Mr O'Donoghue, a humbling and salutary reminder of this.

Improvements

[42] The court notes the defence submissions regarding measures taken to improve safety and ensure that the circumstances surrounding this tragic accident cannot be repeated. It is particularly relevant in this regard that whereas at the time of the accident, approximately 90% of glass was delivered by float liner and approximately 10% delivered by endcap. Since May 2022, there have been no endcap deliveries, and the five endcaps offloaded on 19 May 2022 remain untouched in the loading bay.

[43] In the past, lifting operations were planned, authorised, and actioned by trained operators in accordance with Glas-Seal's SSOW and RA's and in compliance with the GGF Codes of Practice. While the industry regards the lifts involved to be of a basic nature and do not require documented Lift Plans, Glas-Seal decided considering the tragic accident in 2022 to engage a lift consultant (John Curran MCIOB) to assist in the development of Lift Plans and to better manage its approach to controlling lifting operations.

[44] Following the accident in 2022, key employees authorised by Glas-Seal to plan, supervise and carry out lifting operations have been given additional training. Copies of certificates were attached to the file submitted to the court.

[45] Finally, it is submitted by the company that it has an increased level of attention to risk management and training and a greater preparedness to learn and improve. Glas-Seal accepts that maintaining good practice is a work in progress that requires constant attention, reflection, and improvement. Systems, practices, procedures, awareness and training have all improved over the past two years and will be kept under review.

Sentencing issues

[46] I am grateful to counsel for both Crown and defence for their respective submissions in relation to the appropriate framework for sentencing in this case. Whilst Mr O'Donoghue argues that courts in this jurisdiction are not bound by the E&W Sentencing Council guideline, and indeed he strongly counsels the court against doing so, this does rather fly in the face of authority.

[47] There is good reason that a consistent approach is adopted throughout the UK for offences of a similar character relating to breaches of Health and Safety regulations. In this regard the observations of Burgess J in *R v Gallaher (JTI) Limited* [2012] NICC 32 are pertinent:

> "The offence to which the guilty plea has been entered is one for which the principal penalty prescribed by law is an unlimited fine. Where there is no definitive guideline in Northern Ireland then the sentencing court is entitled to refer to the E&W Sentencing Guideline in respect of Health and Safety Offences for assistance. This can provide a useful checklist by which an assessment can be made as to the appropriate level of fine based upon the accepted principles of culpability and harm."

[48] Nevertheless, this court acknowledges that the experience of a small fulltime Crown Court Bench, with a knowledge and appreciation of local factors, allows for a greater flexibility in this jurisdiction to reach a just result without being hidebound by rigid tramlines. This still allows for consideration of the several factors highlighted in the Guideline.

[49] In *Gallaher* Burgess J, (at paras [6]-[8]) noted that the Guidelines are applicable regardless of whether the employer is a company or an individual and they provide:

> "[6]. Seriousness should ordinarily be assessed first by asking:

(i) How foreseeable was serious injury? The more foreseeable it was the graver usually will be the offence.

(ii) How far short of the applicable standard did the defendants fall?

(iii) How common is this kind of breach in this organisation? How widespread was the non-compliance? Was it isolated in extent or indicative of a systematic departure from good practice across the defendant's operations? and

(iv) How far up the organisation does the breach go? Usually, the higher up the responsibility for the breach, the more serious the offence.

[7] In addition, other factors are likely, if present, to aggravate the offence (the list is not exhaustive):

(a) More than one death, or very grave personal injury in addition to death.

(b) Failure to heed warnings or advice, whether from officials such as the Inspectorate, or by employees (especially health and safety representatives) or other persons, or to respond appropriately to "near misses" arising in similar circumstances.

(c) Cost-cutting at the expense of safety.

(d) Deliberate failure to obtain or comply with relevant licences, at least where the process of licencing involves some degree of control, assessment, or observation by independent authorities with a health and safety responsibility.

(e) Injury to vulnerable persons. In this context vulnerable persons would include those whose personal circumstances make them susceptible to exploitation.

[8] Conversely, the following factors, which are similarly non-exhaustive, are likely if present, to afford mitigation:

(a) A prompt acceptance of responsibility.

(b) A high level of co-operation with the investigation, beyond that which will always be expected.

(c) Genuine efforts to remedy the defect.

(d) A good health and safety record.

(e) A responsible attitude to health and safety, such as the commissioning of expert advice or the consultation of employees or others affected by the organisation's activities."

[50] These principles and guidance will provide the context for the court's approach to sentence in this case. The fact that there was no history of similar accidents, impacts upon foreseeability. Against that, where such an accident to occur, the risk of it being serious, or indeed, fatal, was clearly very high. Such a level of risk ought to have been in the contemplation of the company, which should then have taken measures to reduce such risk by ensuring a regular and adequate system of training and monitoring was put in place.

[51] I am, however satisfied that there is no evidence of a systematic departure from good practice across the defendant's operations and furthermore, that none of the potentially aggravating factors highlighted by Burgess J at para [7] of *Gallaher* apply in this case.

[52] In terms of mitigation, I accept the following factors apply:

- The absence of any previous convictions.
- The good health and safety record.
- Full co-operation with the HSENI in the investigation
- There were health and safety measures and training in place.
- The plea of guilty.

[53] I also take note of the fact the company cooperated with HSENI inspections since the accident and that measures are now in place, which include the abandonment of the ***'end cap'*** system of unloading responsible for this fatal accident, which will ensure such a tragedy cannot occur in the future.

[54] I have concluded, notwithstanding the very high level of harm inherent when a fatality occurs, this, of itself, should not lead to an assumption of high culpability on the part of the defendant company. I have already highlighted what I have described as an unintended complacency on the part of the company to the level of risk and consequence where that to crystalise and this to my mind places the defendant company at the **medium** level of culpability, as identified in the Sentencing Council

(E&W) Definitive Guideline. Similarly, the way the operation was carried out established a **medium** likelihood of the harm that then occurred, namely the death of Mr Kilmartin.

[55] The court has been provided with the company accounts for the past three years. In assessing the level of fine the court takes account of the average annual turnover at just less than £5 million, means it falls overall in the ***'small'*** category, that being where annual turnover is between £2M and £10 million. Mr O'Donoghue submits that a reliance upon this figure in isolation may lead to unfairness given the economic pressure on the company as highlighted in the two reports submitted by Sumer (NI). These, he argues, demonstrate the trading position of the company and the challenges it faces to remain viable. This includes the need to make significant capital investment, to remain competitive, in a primary glazing production line.

[56] In terms, the thrust of Mr O'Donoghue's argument is that in assessing a figure that reflects the seriousness of the breach, it must also be fair and proportionate. In some cases where a firm has acted with reckless abandon regarding breaching Health and Safety regulations, a substantial fine, which might result in that company going out of business may be entirely justified. Such is not the case here and I accept that the court should not lose sight of the implications for the workforce and the local community if Glas-Seal, which has an otherwise unblemished record over 50 years were forced to close because of these proceedings.

[57] It is axiomatic to observe that a fine, no matter how substantial, could equate to the loss of life and in fixing the amount in this case, the court specifically does not suggest otherwise. Rather, the fine is assessed according to the several factors both aggravating and mitigating highlighted earlier in this ruling.

[58] Applying these principles to the facts of this case and taking account of the mitigating factors aside from the guilty plea, including the company's ability to meet the fine I take a starting point of **£45,000.00,** which is the sentence I would have imposed had the company been convicted of this charge after a contested trial. I shall allow the maximum discount of one third for the plea at arraignment reducing the fine to **£30,000.00.**

Sentence

[59] Count 1 - Failing to ensure the health and safety of employees – Fine £30,000.00.