Health and Safety Committee

Tue 17 January 2023, 09:00 - 11:00

Agenda

09:00 - 09:10
10 min

1. Welcome & Introductions

Mike Jones

09:10 - 09:10
0 min

2. Apologies for Absence

09:10 - 09:10
0 min

3. Declarations of Interest

09:10 - 09:10
0 min

4. Minutes of the Committee Meeting held on 18 October 2022

1.3 Draft HS Minutes - 18.10.22MD.NF.pdf (11 pages)

09:10 - 09:10
0 min

5. Action Log following the Meeting held on 18 October 2022

1.4 HS Action Log - JanuaryMD.NF.pdf (2 pages)

09:10 - 09:10
0 min

6. Chair's Action taken since last meeting

09:10 - 10:45
95 min

7. Items for Review and Assurance

7.1. Corporate Manslaughter

Nicola Foreman Nigel Fryer

7.1a Corporate Manslaughter Presentation.pdf (9 pages)
7.1b Corporate Manslaugher Discussion paper.pdf (61 pages)

7.2. Health & Safety Overview (Verbal) including

Rachel Gidman Robert Warren

7.2 Health & Safety Overview.pdf (20 pages)

7.2.1. RACI Document

7.2.2. Staff Smoking Update

7.3. Fire Safety Update

Rachel Gidman Robert Warren

7.3 Fire Safety Report.pdf (6 pages)

7.4. Enforcement Agencies Report

Rachel Gidman Robert Warren

7.4 Enforcement Agencies Report.pdf (3 pages)

7.5. Waste Management Compliance Report

Catherine Phillips Geoff Walsh

7.5 Waste Compliance H&S Committee Jan 2023.pdf (5 pages)

7.6. BREAK - 10 Mins

7.7. Ventilation Annual Report 2022

Catherine Phillips Geoff Walsh

The full report is in the Supporting Documents

7.8 Ventilation Report Jan 2023.pdf (5 pages)

7.8. Medical Gas Pipeline Systems (MGPS) AE Report 2021

Catherine Phillips Geoff Walsh

The full report is in the Supporting Documents

7.9 Medical Gas Pipeline Systems (MGPS) Jan 2023.pdf (5 pages)

7.9. Triennial Inspection Annual Report – low Voltage Installation 2022

Catherine Phillips Geoff Walsh

The full report is in the Supporting Documents

7.10 Low Voltage Systems Jan 2023.pdf (5 pages)

10:45 - 11:00
15 min

8. Items for Approval/Ratification

8.1. Policies for ratification:

Rachel Gidman Rob Warren

8.1.1. Sharps Management Policy and Procedure (UHB 269)

8.1 Sharps Management Policy Cover Report.pdf (2 pages)
8.1a Sharps Management Policy and EHIA 2022.pdf (19 pages)
8.1b Sharps Management Procedure 2022.pdf (10 pages)

8.2. Committee Annual Work Plan 2023/24 and Terms of Reference

Nicola Foreman

8.2 Health and Safety ToR and Workplan covering report 23.24.pdf (3 pages)
8.2a Appendix 1.Terms of Reference - January 2023.pdf (7 pages)
8.2b Appendix 2.Health and Safety Committee Work Plan 23.24.pdf (1 pages)

8.3. Health and Safety Committee Annual Report

Nicola Foreman

- 8.3 Health and Safety Committee Annual Report Cover.pdf (2 pages)
- 8.3a Draft Health and Safety Committee Annual Report(1)MD2.pdf (9 pages)

11:00 - 11:00
0 min

9. Items for Noting and Information

9.1. Sub Committee Minutes:

9.1.1. Operational Health and Safety Group – 6.9.22

Rachel Gidman Robert Warren

- 9.1 OHSG Meeting Minutes 6.9.22.pdf (6 pages)

9.2. Fire Prosecution Update (Verbal)

Rachel Gidman Robert Warren

11:00 - 11:00
0 min

10. Any other Business

11:00 - 11:00
0 min

11. Items to bring to the attention of the Board/Committee

Mike Jones

11:00 - 11:00
0 min

12. Review of the meeting

Mike Jones

11:00 - 11:00
0 min

13. Date and time of next meeting

18 April 2023 at 09:00am MS Teams

Unconfirmed Minutes of the Health & Safety Committee
Held On 18th October 2022 at 09:00 am
Via MS Teams

Chair:		
Mike Jones	MJ	Independent Member – Trade Union / Committee Chair
Present:		
Ceri Phillips	CP	UHB Vice Chair
Michael Imperato	MI	Independent Member – Legal
Akmal Hanuk	AH	Independent Member – Local Community
In attendance:		
Rachel Gidman	RG	Executive Director of People & Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Robert Warren	RW	Head of Health and Safety
Janice Aspinall	JA	Safety Representative RCN
Rachael Daniel	RD	Assistant Head of Health and Safety
Jonathan Strachan-Taylor	JS	Safety Representative GMB
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Charles Janczewski	CJ	UHB Chair
Catherine Phillips	CP	Executive Director of Finance
Fiona Jenkins	FJ	Executive Director of Therapies
Nicola Foreman	NF	Director of Corporate Governance
Rachel Sykes	RS	Assistant Head of Health and Safety

Item No	Agenda Item	Action
HS 18/10/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
HS 18/10/002	**Apologies for Absence** Apologies for absence were noted.	
HS 18/10/003	**Declarations of Interest** No Declarations of Interest were noted.	
HS 18/10/004	**Minutes of the Meeting Held on 19 July 2022**	

	The Minutes of the Committee Meeting held on 19 July 2022 were received. **The Health & Safety Committee resolved that:** a) The minutes of the meeting held on 19 July 2022 were approved as a true and accurate record.	
HS 18/10/005	**Action Log – Following Meeting Held on 19 July 2022** The Action Log was received. HS 19/07/007 - The Executive Director of People & Culture (EDPC) confirmed that she would speak with the Chief Executive (CEO) about including the increase in smoking and fire incidents in the Staff bulletin/newsletter. HS 19/07/014 - The Head of Corporate Governance (HCG) advised that she had looked back at the results of the Committee self-effectiveness survey. There was only one item that was flagged as inadequate. That was in relation to agenda setting and feedback had been provided to the Committee at that time. The HCG added that the comments in the survey results were also not picked up by Survey Monkey. It was likely that another tool would be used for all of the Board Committees self-effectiveness surveys next year and that this was being looked into. The HCG would update the Committee in due course. **The Health & Safety Committee resolved that:** a) The Action Log was noted.	EDPC HCG
HS 18/10/006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
	Items for Review and Assurance	
HS 18/10/007	**Health & Safety Overview (Verbal)** The Head of Health & Safety (HHS) presented the Health and Safety (H&S) Overview and highlighted the following: <u>Manual handling</u> • There had been a lot of good work carried out behind the scenes.	

	• The Health and Safety team was working with various Directorates and external manufacturers to trial equipment used for management and rehabilitation of bariatric Patients. • His team was also looking for a supplier for proning patients. • A lot of the work had been carried out in a collaborative way with Clinical staff. • Further sessions were planned for wider Clinical staff, including Nursing staff <u>Lone worker</u> • A new contract had been negotiated and signed. <u>Training</u> • A training needs assessment was being conducted for Manual Handling and Violence and Aggression for roles across the Health Board. • Staff who had not completed that training yet had been identified. • The training team had completed an external verification on their competence to deliver Violence and Aggression training. That followed on from Manual Handling which was completed in June. <u>UHB Classroom Training Compliance</u> • The figures were low at 16.57 % in October 2021. In September 2022 it had increased to 46.3%. It was still in the red category but had slightly increased. <u>Health and Safety Culture Plan Update</u> • His team was progressing the Health and Safety Culture Plan. By the next meeting the team should have a few more themes closed out. • The actions were quite considerable and required a lot of work and detail. The EDPC advised the Committee that there was a lot of “noise” regarding the demand for Manual Handling and Aggression training because staff would not be able get a pay progression unless they had gone through the	

	mandatory training. The EPDC was working through this with the educational team. The Independent Member – Local Community (IMLC) queried if there were any good practices that could be adopted to increase training. The HHS responded that training people who did not need to be trained was one area that was being considered. The Director of Estates, Capital and Facilities (DECF) commented that that there was constant positive reminder that staff were not going through paygrades and increments unless they had completed mandatory training. One issue regarded managers finding time to release staff to undertake the mandatory training. The EDPC stated that it was about reinforcing safety of the staff. It had also been noted, from looking at individual staff records, that many people were duplicating training by attending face to face and online training. More should be done to streamline the training on ESR. <u>Gas Cylinder Incident</u> • There were difficulties in tracing the original users of the cylinder. • The investigation turned to Oracle. It was seen that three purchases had been made. • An assumption was made, on the balance of probability, that the single use purchaser did not know the correct disposal route. • Further investigation found that the department did have the correct disposal processes in place. However the cylinder had rolled off the storage shelf and into the bin below it <u>UHB RACI</u> • 1- 22 elements would be rolled out by the Clinical Boards. • It included all types of responsibilities and arrangements. • It would provide unambiguous ownership of responsibilities in relation to health and safety.	

	The EDPC stated that it would be good to show the RACI document to the Senior Leadership Board so that Clinical Boards could take ownership within their domains. The Executive Director of Public Health (EDPH) commented that it made it clear who had responsibility for the different areas. The EDPH queried where the IPC team was included? It was agreed that the HHS would take it away and consider where the IPC team would go. <u>Staff smoking</u> • The Health Board was under significant pressure from South Wales Fire & Rescue Service (SWFRS). • Staff smoking or vaping on the Health Board sites or inside a building was unsafe. • It was a deliberate violation and should be treated through the consequence management route. • The Health Board's No Smoking Policy which, was underpinned by Welsh Government law, needed to be enforced. • Communication needed to be circulated stating that the Health Board was taking a zero-tolerance approach in relation to any staff found to be smoking on the Health Board's premises. The Independent Member – Trade Union (IMTU) stated that he was worried about the 96 unnecessary fire service calls and that something should be done about enforcing the No Smoking Policy urgently. The EDPC stated that there were pockets of areas where staff were smoking. There should be stronger communication. The EDPH stated that there should be a zero-tolerance policy to smoking. The Health Board had the most progressive policies in Wales. When there was a regular Enforcement Officer at the site, data could be collected. The EDPH added that she was a strong advocate of enforcement. Communications on the issue to Staff had been tried for a long time.	HHS/EDPC

	The Independent Member – Legal (IML) advised that it would be useful to talk about corporate manslaughter. The IMTU requested that the topic of corporate manslaughter should be put on the next Committee's agenda. The EDPH advised that it would be useful to take the smoking item to Management Executive and the Senior Leadership Board (SLB) to emphasise the seriousness of the situation. The EDPH stated that the HHS was due to attend the Senior Leadership Board on 3rd November and that this matter could be raised then. The UHB Vice-Chair queried whether communication reached locums and staff. It might not reach agency staff who work nights. He added that smoking on site also had major cost implications and that point should also be made to SLB. The IMLA queried whether more security cameras could be placed at sites. The DCEF responded that there were many security cameras on site but smokers were likely to find another place on site to smoke. The IMTU advised that he would like to meet with the EDPC, EDPH, and HHS as soon as possible to consider this issue further and to discuss the next steps. The EDPH advised that there needed to be a pan organisation approach and that the matter should be tied in with the Health and Safety Culture Plan. **The Health & Safety Committee resolved that:** a) The Health and Safety Overview was noted.	DCG/IML DCG/HHS DCG
HS 18/10/008	**Fire Safety and Enforcement Report**	

	The HHS presented the Fire Safety and Enforcement Report and highlighted the following: • Mal Perrett, the UHB Senior Fire Safety Advisor, had sadly passed away. • The HHS was currently advertising for two Fire Safety Advisors, one of these was for the Senior Fire Safety Advisor role. • That would increase the team by one. • His team had secured the services of the retired Fire Safety Advisor from Aneurin Bevan University Health Board (ABUHB) for 3 days a week for 3 months. • Fire Safety Week was taking place between 17th October and 21st October. • There was a meeting with the Assistant Chief Fire Officer today to discuss the Letter under Caution. <u>Fire Enforcement</u> • The A4 North handover meeting was the next day. • A4 South would then be removed from operation. <u>Whitchurch Hospital Water Main</u> • There had been two fire events. Firstly, there was a fire in Llanrumney which was extinguished by the Fire Service team. • Another fire was started by a Mental Health Patient in the Emergency Unit toilets. <u>HYC Smoking Incident</u> • A fire alarm was sounded in Hafan Y Coed. A Patient was found smoking in their room. • Despite a detailed search, an ignition source was not found. It was likely that the cigarette was lit in the garden using the Ozzy lighters and brought into the building. • The SWFRS was called and following an onsite meeting, reassurance was provided and no further enforcement notices were issued. The event was recorded as a case note on the Health Board file. <u>Unwanted fire signals</u>	

	• There had been a total of 196 unwanted fire signals to date. • SWFRS have attended the Health Board site 158 times. • This represented a 30% increase in the last 3 months. • Those were largely avoidable events attributed to behaviours. <u>Permit to work</u> • All relevant permit documentation was in place for the work being conducted. • The current hot work permit was generally very good. Suggestions were made to improve hazard identification and documentation governance. • The Director of Estates, Capital and Facilities (DCEF) will specifically review the feedback loop from the work party to the person responsible for removing relevant isolations. • This was likely to involve a phone call and signature. **The Health & Safety Committee resolved that:** a) The report was noted.	
HS 18/10/009	**Environmental Health Food Hygiene Report** The Environmental Health Food Hygiene Report was received. The DECF advised the Committee that the following units were recently inspected: - Hafan Y Coed Unit at University Hospital Llandough (June 2022); - the Teddy Bear Nursery at the University Hospital of Wales (July 2022); - University Hospital Llandough main kitchen, wards and restaurant (September 2022) and - Aroma Unit, University Hospital Llandough (September 2022). All of those units had received a food hygiene score of 5.	

	The EDPH congratulated the team on their focus and leadership in gaining that score. **The Health & Safety Committee resolved that:** a) The achievement of those food businesses with a food hygiene rating of 5 and the associated action plans, were noted.	
HS 18/10/010	**Regulatory and Review Body Tracking Report** The Regulatory and Review Body Tracking Report was received. The Assistant Head of Health and Safety (AHHS) stated that the Report was received by the Committee twice a year. The Report tracked that relevant Board Committees were receiving reports and information regarding inspections undertaken by the various inspection/review bodies as a key source of assurance. Although the Report looked at inspections for the new financial year, it also included those from previous financial years so they did not lose track of them. The AHHS advised that she would add EHO to the tracking report too. **The Health & Safety Committee resolved that:** a) The content of the report was noted.	AHHS
HS 18/10/011	**Risk Register for Health and Safety** The Risk Register for Health and Safety was received. The HHS updated the Committee that the highest current risk ratings were 16, of which two were covered by the Health and Safety Culture Plan. Discussions were currently taking place to determine ownership of the third risk which related to the management of bariatric Patients. The HHS had proposed that this last point be taken	

	forward with an All Wales approach. **The Health & Safety Committee resolved that:** a) The findings of the new identified risks and the actions in place to reduce the risk rating, were noted.	
HS 18/10/012	**Fire Safety Compliance Report** The Fire Safety Compliance Report was received. The IMLA queried whether the Fire Safety training figures had increased. The HHS responded that the Fire Safety training was being held that week. Last year they had trained 3,000 people in under a week. The HHS added that they would not be training the same numbers this year because the venues were not as large enough. **The Health & Safety Committee resolved that:** a) The on-going efforts to meet the requirements of enforcement action and C&V UHB's statutory and mandatory fire safety obligations were considered.	
	Items for Approval/Ratification	
HS 18/10/013	**No items were noted.**	
	Items for Noting and Information	
HS 18/10/014	**Sub Committee Minutes:** i. Operational Health and Safety Group – 06/06/22	
HS 18/10/015	**Any Oher Business** The Safety Representative RCN (SR) informed the Committee that there were housekeeping staff who tidied up Health Board areas in their own time. The SR requested clarification as to whether they were covered under the voluntary aspect of their employment contract.	

	The CC responded that it was very good work by the team and congratulated them. It was his understanding that if their management knew they were doing this, then it was covered under the insurance policy. The EDPH advised that this query should be checked with the EDPC. **The Health & Safety Committee resolved that:** a) Any Other Business was noted.	EDPC
HS 18/10/016	**Items to bring to the attention of the Board/Committee** It was noted that the following should be highlighted to the Board: - Training rates - Unwanted fire signals - RACI document - Staff smoking The HCG advised that she would include these items in the Chairs report. **The Health & Safety Committee resolved that:** a) Items to bring to the attention of the Board/Committee were discussed and noted.	DCG/HCG
	Review of the meeting	
	Date and time of next meeting 17th January 2023 at 09:00am MS Teams	

ACTION LOG
FOLLOWING HEALTH AND SAFETY COMMITTEE MEETING
19 October 2022
(Updated for the meeting 17 January 2023)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions Completed					
HS 19/07/007	RACI document	A new RACI document was being developed and will be brought to the October meeting.	R Warren	18.10.22	**Completed** Discussed at October meeting.
HS 19/07/007	Calibration cylinder investigation	An investigation was being done into the calibration cylinder that was put in a waste bin in UHW. Updates would be provided to the Committee.	R Warren	18.10.22	**Completed** Discussed at October meeting.
Actions in Progress					
HS 18/10/007	Corporate manslaughter	The Independent Member – Legal requested that corporate manslaughter be put on the next committee's agenda.	N Foreman	17.01.23	**Update on 17 January 2023** Agenda item – 7.1
HS 18/10/007	RACI Document	The HHS to confirm where the IPC sat within the RACI Document	R Warren	17.01.23	**Update on 17January 2023**
HS 18/10/007	Staff smoking on Health Board sites	The Committee Chair asked to meet with the EDPC, EDPH and HHS as soon as possible to discuss next steps.	N Foreman	17.01.23	**Update on 17 January 2023** *A meeting took place on 9 November 2023)*
HS 18/10/015	Staff working voluntarily	The EDPC agreed to check that staff working in Health Board areas during their own time were covered by the appropriate insurance.	R Gidman	17.01.23	**Update on 17 January 2023** The EDPC confirmed that volunteers are covered through patient experience and other staff employed are covered through honorary contracts etc.
HS 19/07/007	CEO Bulletin	The EDPC would speak to the CEO about putting the increase in smoking and fire incidents into the staff bulletin.	R Gidman	17.01.23	**Update on 17 January 2023**

					Both PH and H&S have worked with the Communications team and a video has been created with a message from the Chief Executive regarding non-smoking.
HS 18/10/010	Regulatory and Review Body Tracking Report	EHO food inspection to be added to the tracking report.	R Daniel	17.01.23	**Update on 17 January 2023**
HS 19/07/014	Committee Self Effectiveness Survey	The DCG would will look at the results and pick up any comments.	M Donovan	April 2023	**Update in April 2023** Discussed at October meeting. The Corporate Governance Department were considering how to improve the Board Committees' self-effectiveness survey process and would update the Committee on their findings.
Actions referred to other Committees/Board					
HS 18/10/007	RACI Document	The RACI document is to be presented to SLB to allow clinical boards to take ownership.	R Warren	01.12.22	**Completed** Discussed at SLB on 1 December 2022.
HS 18/10/007	Staff smoking	The HHS to discuss the increase in staff smoking on Health Board sites at SLB.	R Warren	03.11.22	**Completed** Discussed at SLB on 3 November 2022.
HS 18/10/016	Items to bring of the attention of the Board	The Committee agreed to highlight the following to the Board:- Training rates, unwanted fire signals, RACI document and staff smoking	M Donovan	24.11.22	**Completed** Those matters were raised in the Chair's Report which went to the Board in November 2022.

PARK PLACE

CARDIFF AND VALE HEALTH BOARD

CORPORATE MANSLAUGHTER

LEGISLATION

PARK PLACE

- The offence of Corporate Manslaughter is set out in Section 1 of the *Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA):-*
- "An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised that;
- (a) causes a person's death, and
- (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased".
- "An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach".

ELEMENTS

PARK PLACE

- There four essential elements that the Prosecution must prove:
- 1) There is an ‘organisation’;
- 2) The way in which its activities are managed or organised causes a person’s death;
- 3) The way in which its activities are managed or organised amounts to a gross breach of a relevant duty of care owed to the deceased;
- 4) The way in which its activities are managed or organised by its senior management is a substantial element in the breach
- The Act only applies to ‘organisations’ as defined by the Act, but the definition is broad and includes public bodies. Crown immunity is expressly removed in under section 11.
- The ‘harm resulting in death’ will typically be the physical injury that proves to be fatal. In the majority of cases, the physical injury causing the death and the death itself occur at the same time, in the same location.

ORGANISATION

PARK PLACE

- The Act only applies to ‘organisations’ as defined by the Act, but the definition is broad and includes public bodies.
- Crown immunity is expressly removed in under section 11.
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DUTY OF CARE

PARK PLACE

- For the offence to apply, the organisation concerned must have owed a 'relevant duty of care' to the deceased. The Act does not create or define duties of care, rather it simply lists certain existing duties of care which are now to be regarded as "relevant". Relevant' duties that are relevant to the NHS are set out in section 2 of the CMCHA: -
- A "relevant duty of care", in relation to an organisation, means any of the following duties owed by it under the law of negligence—
- (a)a duty owed to its employees or to other persons working for the organisation or performing services for it;
- (b)a duty owed as occupier of premises;
- (c)a duty owed in connection with—
- (i)the supply by the organisation of goods or services (whether for consideration or not),
- (ii)the carrying on by the organisation of any construction or maintenance operations,
- (iii)the carrying on by the organisation of any other activity on a commercial basis, or
- (iv)the use or keeping by the organisation of any plant, vehicle or other thing;
- (d)a duty owed to a person who, by reason of being a person within subsection (2), is someone for whose safety the organisation is responsible.

SENIOR MANAGEMENT

- "Section 1(3): 'An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach".
- A substantial part of the failing must have occurred at a senior management level.
- S1(4)(c): '.....the persons who play significant roles in-
- (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or
- (ii) the actual managing or organising of the whole or a substantial part of those activities".
- The Guidance Notes suggest that the definition will probably include, those carrying out 'headquarters' functions (central financial/strategic/health and safety roles) and those in senior operational management roles.
- Exactly who is a member of an organisation's senior management will depend on the nature and scale of an organisation's activities. Apart from directors and similar senior management positions, roles likely to be under consideration include the managers of different divisions.

GROSS BREACH

PARK PLACE

- A ‘Gross breach’ is defined in section 1(4)(b) -

- “A breach of a duty of care is a ‘gross’ breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances”.

- In practice what will and will not be held to be a ‘gross’ breach is likely to be a matter of fact to be decided by the Jury in each case.

BURDEN AND STANDARD OF PROOF

PARK PLACE

There is a fundamental difference between offences preferred under the Health and Safety at Work Act 1974 (HSWA) and the offences of Corporate Manslaughter or Gross Negligence Manslaughter.

s.40 of the HSAW 1974 imposes a reverse burden of proof upon the corporate body, for completeness, s.40 states: -

“In any proceedings for an offence under any of the relevant statutory provisions consisting of a failure to comply with a duty or requirement to do something so far as is practicable or so far as is reasonably practicable, or to use the best practicable means to do something, it shall be for the accused to prove (as the case may be) that it was not practicable or not reasonably practicable to do more than was in fact done to satisfy the duty or requirement, or that there was no better practicable means than was in fact used to satisfy the duty or requirement”.

The reverse burden was a deliberate result of public policy that deemed it was for the corporate body to demonstrate that their system of work was reasonable upon the balance of probabilities (the civil burden).

The offence of Corporate Manslaughter contains no such reverse burden. The burden to prove the offence remains with the Prosecution and is set at the higher criminal standard. Any Jury must be sure of the guilt of the corporate body in order to convict.

This burden is extremely important when the Crown determine the question of whether to prosecute. Any such decision is based upon the Code for Crown Prosecutors .

This is a two-stage test, evidential and public interest. In order to meet the evidential test the Crown must conclude that there is realistic prospect of conviction upon consideration of all the evidence. Compared to Health and Safety offences, Corporate Manslaughter is much harder to prove and therefore the Crown will think very carefully before instigating proceedings.

MAIDSTONE AND TONBRIDGE WELLS NHS TRUST

PARK PLACE

- Case Study and Discussion.

- Please see additional analysis provided.

CARDIFF AND VALE HEALTH BOARD

MAIDSTONE AND TONBRIDGE WELLS
NHS TRUST:
CASE STUDY AND DISCUSSION

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1. The first attempt to prosecute an NHS Trust for Corporate Manslaughter came in 2015 when Maidstone and Tonbridge Wells NHS Trust (Maidstone) was prosecuted following the death of a 30 year old school teacher, Frances Cappuccini, after she underwent an emergency caesarean section at Tunbridge Wells hospital in Kent.

2. The Prosecution alleged that two of the doctors responsible for her care lacked vital qualifications and experience and that there were serious shortcomings in supervision.

3. Errol Cornish, a locum consultant anaesthetist, was also indicted individually of gross negligence manslaughter.

4. Dr Nadeem Azeez, who the prosecution said was primarily responsible for Mrs Cappuccini's care, would have faced trial for gross negligence manslaughter had he not fled to Pakistan.

5. Mrs Cappuccini suffered a cardiac arrest shortly after her surgery in October 2012 and died as a result of high levels of acid in her blood due to a lack of oxygen.

6. The Prosecution case alleged that if one or both doctors was found to be grossly negligent then the Trust had employed someone it knew, or should have known, was not suitably qualified or trained.

7. The Judge, Culson J, ruled, "there is no question that Frances Cappuccini should not have died at the trust hospital on the 9th of October", but went on to outline that there were a number of flaws in the prosecution case including evidence that showed some of Dr Cornish's actions had been "about as far from a gross negligence manslaughter case as it is possible to be".

8. The trial Judge instructed the Jury at Inner London Crown Court to acquit the Trust and Dr. Cornish, just over two weeks into the trial, having ruled that they had no case to answer.

PRELIMINARY RULING

9. Coulson J gave a preliminary ruling that examined a number of aspects of the legislation. This is important because it was the first time it had been considered in the context of an NHS Trust.

10. Unsurprisingly he identified the ingredients of Corporate Manslaughter that are set out with the legislation, namely: -

11. a relevant duty of care,

12. activities which were managed or organised by senior management in a way which comprised a breach of the NHS Trust's duty,

13. in all the circumstances, that breach was gross,

14. the gross breach caused or made a significant contribution to the death.

15. Coulson J made clear that it was necessary to adopt a careful analysis of each element of the offence and not merely consider the evidence of a case 'in the round'.

DUTY OF CARE

16. The existence of a relevant duty of care was conceded by the NHS Trust, although it is difficult to imagine a Corporate Manslaughter case arising out of medical treatment in which the NHS could deny the existence of a duty of care.

MANAGEMENT

17. Two potentially important points arose from Coulson J's consideration of the second ingredient of the offence—'the way in which its activities are managed or organised by its senior management'.

18. First, he ruled that the prosecution was permitted a degree of vagary in identifying the relevant 'senior management' for the offence. This is important; indeed, it confirms the position in Tesco v Natrass, that for the purposes of prosecution the Crown do not need to particularise in precise detail the chain of command, responsibility or controlling mind. Senior management is collective and determination of identifying who is senior management is a matter of fact rather than law .

19. Coulson J rejected “out of hand’ the Trust’s submission that ‘in some way the case against the Trust should be stopped because the precise tier or the precise individuals involved in the Trust’s management had not been identified’.

20. One of the reasons given by Coulson J for refusing to find that the Prosecution had failed to adequately particularise the senior management was that the Prosecution had called expert evidence about how an NHS Trust would and should be organised. A jury could, from that evidence decide who was the relevant ‘senior management’. This is significant, as it confirmed that the issue of identifying senior management is as much a question of fact as a question of pleading. It would be open to any Defendant to challenge the Prosecution’s view of who constitutes “relevant senior management”. A lack of particularisation by the Prosecution is unlikely to lead to the case failing, ultimately it is a matter for the Jury to determine based upon evidence of fact and expert.

21. Second, Coulson J took a limited view of CMCHA 2007, s 1(3) which provides that:

22. ‘An organisation is guilty of an offence under this section if the way in which its activities are managed or organised by its senior management is a substantial element in the breach...’

23. If taken at face value, CMCHA 2007, s 1(3) may give the Prosecution room to argue that the offence is intended to cover both systematic failures (errors in ‘organisation’) and specific errors (errors in how a particular situation or decision was ‘managed’).

24. However, Coulson J was careful to distinguish between systematic errors and ‘one-off’ errors. He contrasted ‘systematic failure’, with individual ‘one-off errors’, concluding that “one-off” failings were not capable of amounting to relevant breaches of corporate manslaughter.

25. The ruling of Coulson J will not bind any future prosecution, as it was not a ruling of the Higher Courts, however it will certainly be persuasive, due to its logical conclusions.

GROSS FAILURE

26. Coulson J held that the phrase “gross” should be interpreted consistently with the case law on gross negligence manslaughter. He adopted the various tests set out in the familiar line of authorities, which emphasise the high threshold and the seriousness of the conduct required in order to elevate a mistake or negligence to a serious crime.

27. The relevant standard was summarised as being conduct which “fell so far below the standards to be expected...[and] was so flagrant and so atrocious that it would consequently amount to a crime”. This is an extremely important point, as it confirms the high bar the

Prosecution must overcome in order to establish the offence. In short, the circumstances must be so bad that they move from being considered a regulatory breach/negligence to criminal conduct. The assessment of “gross” negligence manslaughter focuses the level of risk created by a breach of duty, not at the level of harm actually created.

28. This is the critical element in this matter; whether the systemic failures outlined above are capable of amounting to a “gross” failure. If they are not, then there is not a realistic prospect of conviction.

29. As noted, Coulon J was clear that the threshold for determining whether the facts amounted to a “gross” failure was high. The seriousness of the conduct required in order to elevate a mistake or negligence to a serious crime must be grave. He stated that the phrase should be determined in the same way that it is in cases of Gross Negligence Manslaughter.

30. This must be right. The NHS is a substantial public body and, notwithstanding the efforts of those that work in the organisation, it is a hard truth that patients will die each year because of systemic failure. Those failures can range from delayed ambulances to the quality of equipment. It would be wrong to criminalise all deaths. This is why there is a clear division between HSWA legislation and that for Corporate Manslaughter.

31. The bar for proving breaches of HSWA is much lower than that required for Corporate Manslaughter.

32. The Act describes “gross” as, “A breach of a duty of care is a ‘gross’ breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances”.

33. Section 8 sets out the considerations for a Jury in determining whether it is a gross breach:

    (1) This section applies where—

    (a) it is established that an organisation owed a relevant duty of care to a person, and

    (b) it falls to the jury to decide whether there was a gross breach of that duty.

    (2) The jury must consider whether the evidence shows that the organisation failed to comply with any health and safety legislation that relates to the alleged breach, and if so: -

(3)
(a) how serious that failure was;
(b) how much of a risk of death it posed.

The jury may also—

(a) consider the extent to which the evidence shows that there were attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged any such failure as is mentioned in subsection (2), or to have produced tolerance of it;
(b) have regard to any health and safety guidance that relates to the alleged breach.

(4) matters they consider relevant.

This section does not prevent the jury from having regard to any other matters they consider relevant. (This includes breaches of Health and Safety Legislation).

34. The law relating to Gross Negligence Manslaughter was clarified by the House of Lords in the case of Adomako [1995] 1 A.C. 171 .

35. The ordinary principles of the law of negligence apply to determine whether the defendant was in breach of a duty of care towards the victim; on the establishment of such breach of duty the next question is whether it caused the death of the victim, and if so, whether it should be characterised as gross negligence and therefore a crime; it is for the a jury to determine the question on the facts, having regard to the risk of death involved, the defendant's conduct was so bad in all the circumstances as to amount to a criminal act or omission.

36. In Rebelo (No.1) [2019] EWCA Crim 633 and subsequently in Broughton [2020] EWCA Crim 1093, the Court of Appeal summarised the matters upon which the Jury had to be directed

(a) Firstly, that the defendant owed an existing duty of care to the victim.
(b) Secondly, the defendant negligently breached that duty of care.
(c) Thirdly, at the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation.
(d) Fourthly, it was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death.
(e) Fifthly, the breach of the duty caused or made a significant (ie. more than minimal) contribution to the death of the victim.

(f) Finally, in the view of the jury, the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.

CAUSATION

31. There will be no liability unless the breaches are the factual and legal cause of the death. Coulson J was clear that, a Corporate Manslaughter conviction does not depend upon a conviction for gross negligence manslaughter by an individual employee. A corporate manslaughter case against a corporate body "exists wholly independently" of a gross negligence manslaughter case against any individuals working for the body. Equally, there is no reason that a criminally culpable failing by an employee should also demonstrate a criminally culpable failing of management or organisation by senior management.

Neutral Citation Number: [2015] EWHC 2967 (QB)

Case No: T20157298

INNER LONDON CROWN COURT

Date: 16 October 2015

Before:

THE HON MR JUSTICE COULSON

- -

R
- v -
Dr Errol Cornish **First Defendant**
and
Maidstone and Tunbridge Wells NHS Trust **Second Defendant**

- -
- -

Mr John Price QC and **Ms Sarah Campbell**
(instructed by **Crown Prosecution Service**) for the **Prosecution**
Mr Ian Stern QC and **Mr James Leonard**
(instructed by **Radcliffes LeBrasseur**) for the **First Defendant**
Mr John Cooper QC and **Mr Mike Atkins**
(instructed by **DAC Beachcroft**) for the **Second Defendant**

Hearing date: 16 October 2015

- -

Judgment

The Hon. Mr Justice Coulson:

1. INTRODUCTION

1. These proceedings arise out of the tragic death of Mrs Frances Cappuccini on 9 October 2012 at Pembury Hospital in Tunbridge Wells. Earlier that day her second son Giacomo was safely delivered by Caesarean section. Thereafter Mrs Cappuccini suffered extensive bleeding and was transferred to theatre for an examination under anaesthetic. It is the Crown's case that, from this point on, grave errors were made by the anaesthetists who were caring for Mrs Cappuccini, with the result that she fell into cardiac arrest. She died at 4:20pm that afternoon.

2. Two anaesthetists are identified in these proceedings. The first to treat Mrs Cappuccini was Dr Nadeem Azeez. He returned to Pakistan during the investigation into Mrs Cappuccini's death and has not returned. He has not been charged. The second anaesthetist was Dr Errol Cornish, the first defendant in these proceedings, who is charged with the manslaughter of Mrs Cappuccini by gross negligence.

3. Both anaesthetists were employed by the Maidstone and Tunbridge Wells NHS Trust ("the Trust"). They are charged with corporate manslaughter contrary to Section 1(1)

of the Corporate Manslaughter and Corporate Homicide Act 2007 ("the 2007 Act"). There is a suggestion in the papers that this is the first time that an NHS Trust has been the subject of such a charge. The particulars of the offence are in these terms:

> "MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST being a body corporate, on the 9th day of October 2012 caused the death of Frances Cappuccini by a gross breach of its duty of care owed to the said Frances Cappuccini, of which breach the management and organisation of its activities by the senior management of the said NHS Trust was a substantial element, in that it failed to take reasonable care to ensure that the anaesthetists involved in the care of Mrs Cappuccini held the appropriate qualifications and training for their role and further failed to take reasonable care to ensure that there was the appropriate level of supervision for the anaesthetic treatment of Mrs Cappuccini."

4. At a hearing on 4 August 2015, Singh J transferred the hearing of the trial in this case from Maidstone Crown Court to Inner London Crown Court. The trial is fixed to start on 12 January 2016. I have been designated as the trial judge.

5. At the same hearing, Singh J fixed this hearing in order that I could "hear legal arguments on two applications" by the Trust. These two applications are:

   (a) That the Crown should be ordered to abandon those aspects of their case that relate to events before the 2007 Act came into force, or prosecute for manslaughter by gross negligence at common law instead of corporate manslaughter;

   (b) That the Crown provide "proper particulars of the allegations that the way in which the Trust's activities were managed or organised by senior management was a substantial element in the alleged gross breach of duty".

6. In addition, there is a third issue which I am asked to decide, which relates to the precise label to be attached to today's hearing. This goes only to the question of any appeal from my ruling on the issue at paragraph 5(a) of above.

7. I am very grateful to all the counsel for their efficient and concise written and oral submissions. The issues between them were, as they emerged, relatively straightforward. However, in order for me to deal with them satisfactorily, it is, I am afraid, necessary to set out rather a lot of background material.

2. THE APPLICATION IN RESPECT OF THE 2007 ACT

2.1 The Issue

8. The Trust's submission is that, because the 2007 Act came into force on 6 April 2008, the Crown cannot rely on any events which took place before that date in support of the charge of corporate manslaughter. In particular, they say that the references in the Case Summary to the appointment of Dr Azeez in 2007, and the upgrading of his rank on 1 April 2008 to that of speciality doctor, cannot form part of the charge under

Section 1(1) of the 2007 Act. The Trust would like the Court to order, either that such allegations (and the evidence relating to them) be abandoned; or that instead there should be a prosecution for gross negligence manslaughter.

9. The relevant parts of the 2007 Act are as follows:

(a) Section 1 sets out the offence:

"The Offence

(1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised—

(a) causes a person's death, and

(b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

(2) The organisations to which this section applies are—

(a) a corporation;

(b) a department or other body listed in Schedule 1;

(c) a police force;

(d) a partnership, or a trade union or employers' association, that is an employer.

(3) An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1).

(4) For the purposes of this Act—

(a) "relevant duty of care" has the meaning given by section 2, read with sections 3 to 7;

(b) a breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances;

(c) "senior management", in relation to an organisation, means the persons who play significant roles in—

(i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or

> (ii) the actual managing or organising of the whole or a substantial part of those activities."

(b) Section 20 abolishes the offence of gross negligence manslaughter in so far as it relates to companies:

> "20. Abolition of liability of corporations for manslaughter at common law
>
> The common law offence of manslaughter by gross negligence is abolished in its application to corporations, and in any application it has to other organisations to which section 1 applies."

(c) Section 27 sets out various transitional provisions:

> "27 Commencement and savings
>
> (1) The preceding provisions of this Act come into force in accordance with provision made by order by the Secretary of State.
>
> (2) An order bringing into force paragraph (d) of section 2(1) is subject to affirmative resolution procedure.
>
> (3) Section 1 does not apply in relation to anything done or omitted before the commencement of that section.
>
> (4) Section 20 does not affect any liability, investigation, legal proceeding or penalty for or in respect of an offence committed wholly or partly before the commencement of that section.
>
> (5) For the purposes of subsection (4) an offence is committed wholly or partly before the commencement of section 20 if any of the conduct or events alleged to constitute the offence occurred before that commencement."

10. Reference was also made to paragraph 66 of the Explanatory Notes that went with the Act. This made it clear that the 2007 Act was not retrospective, and referred to the common law offence of manslaughter by gross negligence remaining in place. In addition, the guidance issued by the Ministry of Justice in October 2007 also made plain that the reform was not retrospective, but reiterated that it would no longer be possible to bring proceedings for gross negligence manslaughter against a company. It referred to Section 27(4) as dealing with cases that occurred wholly or partly before the new offence came into force, and said that prosecutions in those cases would continue to be possible, even after 6 April, on the basis of the existing common law. The legal guidance issued by the CPS to their prosecutors repeated many of the same points.

11. The possible difficulties with the operation of the transitional provisions were discussed, albeit briefly, at the end of an article on the 2007 Act by Peter Ferguson, at [2007] S.L.T 251. The thrust of that article was unsurprisingly concerned with the particular consequences for the law in Scotland, although it does provide some useful background.

12. In my judgment, much the greatest assistance could be found in the judgment of HHJ Gilbart QC (as he then was) in ***R v Lion Steel Equipment Limited and others*** 4 May 2012 (unreported). There, count 1 was a charge of corporate manslaughter against Lion Steel following the death of an employee who fell through the roof when repairing a leak. That happened just seven weeks after the 2007 Act came into force. Count 2 was a charge of manslaughter against three named directors. Lion Steel argued that count 1 could not be proceeded with because it was based entirely on the failure of the company to act on warnings which had been given over the previous years (to the effect that the roof was unsafe), all of which predated the coming into force of the 2007 Act.

13. The learned judge concluded that, before Lion Steel had alerted the Crown to the commencement date point, it was (wrongly) approaching the case on the basis that it could rely on all of the preceding management failures, regardless of when they occurred. The judge ruled that the Crown could not look to evidence of "activities", or whether they involved a "breach" or a "gross breach" of duty, where such activities, breach or gross breach occurred before the date of commencement, "save in so far as they are relevant to the exercise of a duty on and after that date, or whether a breach after that date was a gross breach": see paragraph 27 of the judgment.

14. The judge did not agree with Lion Steel's submission that the evidence about the pre-commencement events should be excluded altogether. He said that such a submission was "wrong and indeed entirely unrealistic"; and that Section 27 was "not an exercise in amnesia". The judge concluded that count 1 could proceed, provided the jury was only asked to consider events before the commencement date in the context of "(i) informing their decision as to whether the senior management knew of facts as at 6 April 2008 or later, or (ii) whether their knowledge of past events rendered their conduct as at 6 April 2008 or afterwards as amounting to a gross breach of the duty upon them" (paragraph 46 of the judgment).

2.2 Submissions

15. On behalf of the Trust, Mr Cooper QC submitted that:

    (a) The offence of corporate manslaughter does not apply to anything done or omitted before 6 April 2008;

    (b) A case which relies upon evidence of acts or omissions prior to 6 April 2008 cannot be brought under the 2007 Act;

    (c) The transitional provisions expressly envisage liability for offences committed partly before that date being pursued under the common law, not the 2007 Act; and

(d) The references in the case summary, to the effect that Dr Azeez should not have been appointed as a locum staff grade doctor (16 July 2007), or a substantive staff grade doctor (1 October 2007), or that that he was inappropriately assimilated into the speciality doctor grade (1 April 2008), cannot form part of a charge under Section 1 of the 2007 Act.

16. On behalf of the Crown, Mr Price QC submitted that:

(a) The indictment makes clear that the offence of which the Trust is accused was committed on 9 October 2012, and the particulars indicate what breaches had occurred, or were occurring , on that date;

(b) Section 27 is concerned only with retrospectivity of criminal liability. It is not concerned with the relevance or admissibility of evidence which is not, and need not, be confined to events occurring on 9 October 2012, or indeed the period after 6 April 2008.

(c) Evidence concerning the appointment of Dr Azeez in 2007/2008 is relevant to the alleged breaches on 9 October 2012 because, for example, that may go to what the Trust knew or ought to have known about his training and qualifications as at 9 October 2012.

2.3 Analysis

17. In my view, it would not be appropriate either to order the Crown to abandon their reliance on any events in 2007 or early 2008, or to order them instead to prosecute for manslaughter by gross negligence at common law. Subject to the particular caveat that I address in paragraph 20 below, the Crown's case, as currently set out in the case summary, does not offend against the 2007 Act. There are a number of reasons for that conclusion.

18. Firstly, as a matter of commonsense, it would, I think, be wrong to suggest that any prosecution for corporate manslaughter would have to be abandoned simply because it referred to an event that occurred before 6th April 2008, even if there was no suggestion of any criminal liability until four and a half years after that date. I think that would be contrary to the purpose of the 2007 Act.

19. Secondly, I consider that what matters in this case is the run up to and the events on 9 October 2012, not events which occurred five years before Mrs Cappuccini was even admitted to hospital. In that respect, it is not dissimilar to the situation where a defendant is charged with offences under the Sexual Offences Act 2003. Whilst that defendant cannot be charged with offences under that Act that were committed before it came into force, that does not preclude the Crown from addressing, in evidence (whether by way of background or bad character or howsoever), any events that might be relevant to the offences with which he is charged, even if those events occurred before the Act came into force.

20. There can be no doubt that the pre-commencement events in 2007 and early 2008 cannot be activities to found the charge of corporate manslaughter. So for example, Dr Azeez's appointment in 2007 cannot, of itself, be an activity that goes to that charge. But that and other pre-commencement events could be relevant to the charges

which are brought under the 2007 Act, in the way outlined by HHJ Gilbart QC in ***Lion Steel***, which I have cited at paragraph 14 above. They do not found the charge, but they may be relevant to it.

21. It was not my understanding that Mr Price QC disagreed with that analysis. In addition, I note that paragraph 112 of the Case Summary puts the corporate and gross negligence manslaughter allegations in this way:

> "**Summary**
>
> 112. In summary the allegations against the three defendants are as follows:
>
> - **Dr Azeez**: that he breached the duty of care he owed Mrs Cappuccini by failing, between 12:35 and 14:10, to re-intubate Mrs Cappuccini when it was apparent to him that she was unable to adequately breathe independently. It is alleged that this was a gross breach of duty because the failure was "a failure of fundamental anaesthetic practice" and a failure to perform "actions that would have been expected of the most junior doctor let alone an anaesthetist".
>
> - **Dr Cornish**: that he breached the duty of care he owed to Mrs Cappuccini by failing, between 13:00 and 14:10, to re-intubate Mrs Cappuccini when it was apparent to him that she was unable to adequately breathe independently. It is alleged that this was a gross breach of duty because the failure was "a failure of fundamental anaesthetic practice" and a failure to perform "actions that would have been expected of the most junior doctor let alone an anaesthetist".
>
> - **Maidstone and Tonbridge Wells NHS Trust**: that the way the Trust's activities were managed or organised by its senior management breached the duty of care it owed to Mrs Cappuccini by:
>
> - Appointing Dr Azeez to perform a role he was not qualified to do;
>
> - failing to assess and supervise Dr Azeez in accordance with National Guidance;
>
> - failing to ensure a process for the identification and recording of the consultant anaesthetist responsible for Mrs Cappucini's care; and failing to comply with the Code of Practice when appointing Dr Cornish as locum consultant

> and that these failures amount 'to a gross breach of that duty and that they caused the death of Mrs Cappuccini."

The first bullet point relating to the Trust refers to the appointment of Dr Azeez. For the reasons I have given, that cannot be a constituent element of the charge of corporate manslaughter. Mr Price QC accepted that, saying that this was a mistake, and that the word *appointing* should be replaced by the word *employing*. On that basis, I am satisfied that the allegations set out in the Case Summary do not offend against the 2007 Act.

22. Thirdly, I consider that s.27(3) of the 2007 Act is dealing with single acts or omissions. It is not dealing with what might be called a continuing omission which existed both before and after the relevant commencement date. Assume for this purpose that Dr Azeez should not have been employed by the Trust in October 2007, because his qualifications and training were inadequate. That cannot form a constituent element of the charge under the 2007 Act, for the reasons that I have given. But if he received no subsequent training, and his qualifications remained inadequate, then it may be said that the Trust should not have continued to employ him after 6 April 2008, and should not have been employing him on 9 October 2012. On that analysis, the material omission was on or around 9 October 2012, and the fact that it can be traced back to 2007 is, in my view, immaterial.

23. I consider that this analysis reflects real life. It also works the other way. Assume that the Trust should not have appointed Dr Azeez in 2007, but that thereafter he did a number of training courses, enhanced his qualifications, and satisfied a rigorous appraisal process, so that by 2012 no criticism could be made of his continuing employment. On that basis, of course, there would be no relevant act or omission by the Trust and no breach of s.1.

24. Although Mr Cooper QC argued that it was not possible to bring pre-commencement acts or omissions within the scope of the 2007 Act merely by 'relying on corresponding post-commencement failures to reverse them', I do not think that that is what the Crown are doing. As I have said, it seems to me that the Crown's case is based entirely on a consideration of the position as at 9 October 2012. Moreover, I do not think that the Crown's case (or my analysis of it) is particularly radical or novel. Indeed I think it is what HHJ Gilbart QC had in mind when he said, at paragraph 27 of his judgment in ***Lion Steel***, that events prior to commencement can be relevant to the existence of a duty after commencement.

25. Of course, depending on the evidence, it may be more difficult for the Crown to prove that the Trust should have done something positive about Dr Azeez in 2012 (once he was an employee), than it would be to prove they should not have offered him a post in the first place. But that is an evidential matter, and is far down the line, a matter for the trial itself. It does not go to whether or not the Trust is properly charged with corporate manslaughter.

26. Finally, I note that at paragraph 39 of his judgment, HHJ Gilbart QC said:

> "…I do not accept the common view of the Crown and of LSEL that, in the circumstances of this case, LSEL could be prosecuted at common law for manslaughter where the death

> only occurred after the common law offence had been abolished. (And it should be noted that section 20 does not just prevent prosecution; it abolishes the offence in its application to corporations). In my judgement nothing in section 27 enables a prosecution to be brought against a company in the circumstances of this case for the common law offence of manslaughter by gross negligence, where the death occurred after the commencement date.

Judge Gilbart QC's observations seem to me to have some force. They obviously run counter to Mr Cooper QC's submission to me. However, since I have decided the application under the 2007 Act on other grounds, it is unnecessary for me to comment further on the judge's approach.

27. Accordingly, for all those reasons, I do not accede to the Trust's first application.

3. THE PARTICULARS OF THE ALLEGATIONS

3.1 The Issue

28. The particulars of the corporate manslaughter count I have set out in paragraph 3 above. The Trust complains that this is wholly inadequate for them to understand and prepare for the trial. The Crown on the other hand, refers to the lengthy Case Summary and says no further particulars can or will be given. The Trust's principal complaint is that the relevant senior management (referred to in Section 1(4) of the 2007 Act) have not been identified. There is also a suggestion that the claim should and could be better particularised as to the breaches alleged.

29. On the identification issue, I notice that Mr Ferguson's article (paragraph 11 above), on which the Trust relied for other purposes, said that the 2007 Act:

> "…arises out of widespread concern at the general inability of the criminal law to fix complains with liability for the deaths caused by their actings. Both Scotland and England and Wales apply the identification principle as the only means of ascribing liability to limited companies. Both jurisdictions have found that the successful prosecution of companies other than one man organisations, is therefore virtually impossible."

Cases in which the identification procedure precluded or significantly hampered the prosecution of a company for manslaughter include ***Transco PLC v HM Advocate*** [2004] JC 29 and ***R v HM Coroner for East Kent*** [1989] 88 Crim App R 10 (the case arising out of the Herald of Free Enterprise disaster).

30. As to the provision of particulars more generally, I have been referred to the case of ***R v Chargot Limited*** [2008] UKHL 73, where the House of Lords said that the overriding test is one of "fair notice". Their lordships made clear that, although fairness required giving notice of the relevant allegations, if they were not ingredients of the offence, it did not necessarily mean that each of them had to be proved.

3.2 The Submissions

31. On behalf of the Trust, Mr Cooper QC submitted that:

    (a) The Crown must prove that the way in which the Trust's activities were managed or organised, by its senior management, was a substantial element in any gross breach of a relevant duty of care;

    (b) The Crown had failed to identify either the person or persons responsible for the breaches or the relevant tier of management, or even to show that there was any senior management involvement;

    (c) The Crown should provide proper particulars identifying the senior managers or at least the tier of management said to be responsible for any gross breach, and explaining how their conduct is said to have been a substantial element in any such breach.

32. On behalf of the Crown, Mr Price QC submitted that:

    (a) The Case Summary for the PCMH was very detailed and provided proper particulars of the case against the Trust;

    (b) The identities of those performing senior management roles were something best known to the Trust itself;

    (c) It was not necessary to identify by name the senior management, because here what mattered was the nature of the relevant activity, namely "the employment/assignment/supervision of senior doctors". The jury would be entitled to infer that such an activity would necessarily have been the responsibility of senior Trust management, and if not, that was itself a breach;

    (d) One of the purposes of the 2007 Act was to do away with the identification doctrine which had caused the failure of a number of significant prosecutions in the past.

3.3 Analysis

(i) Identification

33. Taking the issues in stages, I am no doubt that the Crown does *not* have to name the individuals whom, they say, failed to carry out their management functions properly. That would, I think, be unnecessarily onerous. It would also be artificial, because the names of those involved will be much more likely to be known to the Trust rather than to the Crown. It would be a return to precisely the difficulties of identifying the 'controlling mind' which bedevilled the common law position before the 2007 Act.

34. I have not found the alternative suggestion, namely that the Crown should at least identify the relevant tier of management where the default occurred, very easy to decide. On the one hand, I recognise that Section 1(3) of the 2007 Act makes the organisation of the relevant activities by senior management an ingredient of the s.1 offence. I also note that the CPS guide to its own prosecutors on the subject of corporate manslaughter seems to suggest that some detail must be provided. Indeed one paragraph says this:

> "Neither 'significant' nor 'substantial' are defined but the former is likely to be limited to those whose involvement is influential and will not include those who simply carry out the activity. When considering a prosecution under the Act it is essential to obtain an organogram of the organisation in order to identify the senior management and to use that information to determine whether a substantial element of the breach was at a senior management level."

35. On the other hand it is not, I think, helpful or an appropriate use of resources, to expect the CPS to delve deep into the labyrinthine management structures of any large NHS Trust like this one. It is not for them to identify precisely who should have been doing what on 9 October 2012. Not only would that be a difficult exercise for the CPS, it might also be impossible to obtain a precise answer: I note that, in this case, there appears to be an argument between those working for the Trust as to who was actually supervising the anaesthetists on the day of Mrs Cappuccini's death. If the Trust is unclear about this aspect of their hierarchy, how can the Crown be expected to know better?

36. I have to stand back from this debate and try to be realistic. I am sure that the Trust must have some idea of who (in terms of their senior management) may be thought to bear some managerial responsibility for what happened. On the other hand, I do recognise the need for the Crown to do more than simply assume that this was a matter for senior management and that, if somehow it was not, the breach and/or the gross breach prove themselves.

37. Trying to find a balance between those competing positions, I have come to this conclusion. I think the right answer is to require the Crown to identify the tier of management that it considers to be the *lowest* level of the senior management team within the Trust that is culpable of this offence. It may well be that, subsequently, it will be demonstrated that the relevant tier of senior management was above the level identified by the Crown. But that will not be a difficulty, because any higher tier will be caught by the Crown's identification of the lowest level of senior management with a responsibility for these events.

38. The effect of this order will be to allow the Trust to know that the management tiers *below* that tier identified by the Crown are irrelevant to the Crown's case, and that therefore those particular witnesses would not need to be interviewed, proofs taken etc. It will also require the Crown to particularise the case against that tier of senior management by reference to the ingredients in s.1 of the 2007 Act, so that it is clear how and why the management and organisation of the Trust's activities by that level of senior management caused or was a substantial element in Mrs Cappuccini's death and amounted to a gross breach of its duty of care.

39. Beyond that, I am not prepared to order, because to do so would, I think, place an impossible burden on the Crown. I also think it would be contrary to the 2007 Act, which was designed to provide a way round the identification issues created by the charging of a company with manslaughter at common law.

(ii) Acts and Omissions

40. I discussed with leading counsel for the Crown and both defendants the issue of particulars more generally. This was fairly raised by the Trust's application and it was also something which, independently, I considered to be of some importance. I concluded that the Crown should provide particulars of the acts and omissions relied on against the anaesthetists, and the breaches or gross breaches of duty that they allege against the second defendant. I think that is in accordance with the 'fair notice' principle. In the present case, whilst those particulars may largely be taken from the existing Case Summary, they are capable of being stripped down into essentially two lists. First, the acts and omissions on the part of the anaesthetists, which they say caused Mrs Cappuccini's death; and secondly, the management or organisation failures by the Trust which (so it is said) created the circumstances in which the anaesthetists' acts and omissions occurred and amounted to a gross breach of duty by the Trust. This second list is likely to comprise exactly the same information which I have already required the Crown to provide in paragraph 38 above.

41. The conclusion that those two lists (or something like them) should be prepared by the Crown, is not intended to be a criticism of the current Case Summary. But that document is endeavouring to do rather more than simply identifying the kernel of the case against the defendants, and is an unwieldy instrument for that purpose. Furthermore, as I pointed out to Mr Price QC, the Case Summary contained the usual caveat that the Crown was not bound by its contents, whilst what I have in mind is some form of document by which the Crown is bound, certainly in terms of the proper notice of the allegations on which they rely at trial.

42. Thus, the provision of particulars in the form that I have in mind would allow both defendants to know the case they have to meet. Perhaps even more importantly, as I also discussed with leading counsel, it will provide a proper agenda for the experts. It will be important at the trial to ensure that the expert evidence is properly controlled. In my view, the best way of ensuring that that will happen is for the experts to meet 'without prejudice', to go through the two lists which I have indicated, identifying what they agree and what they disagree on, and setting out brief reasons for their disagreement. That will then form clear parameters for their oral evidence.

43. For those reasons, therefore, I consider that particulars of these two parts of its case should be provided by the Crown as soon as possible. I do not make a specific order to that effect because all counsel agreed that it was a good idea, and Mr Price QC indicated that the particulars would be provided. As I have already said, the management information which I have said is required anyway (paragraphs 37 and 38 above) will probably form the second part of the particulars of its case to be provided by the Crown.

4. THE NATURE OF THIS HEARING

4.1 The Issue

44. The Trust ask that I designate this hearing as a preparatory hearing under Section 29(1) of the Criminal Procedure and Investigations Act 1996 ("the 1996 Act"). The Crown say that I should not. This designation is relevant to the Trust's right of appeal. If it is a preparatory hearing, they can appeal; if it is not, they cannot.

45. Section 29 of the 1996 Act provides as follows:

"29. Power to order preparatory hearing**.**

(1) Where it appears to a judge of the Crown Court that an indictment reveals a case of such complexity, [a case of such seriousness] or a case whose trial is likely to be of such length, that substantial benefits are likely to accrue from a hearing—

(a) before [the time when the jury are sworn], and

(b) for any of the purposes mentioned in subsection (2),

he may order that such a hearing (in this Part referred to as a preparatory hearing) shall be held…

(2) The purposes are those of—

(a) identifying issues which are likely to be material to the determinations and findings which are likely to be required during the trial,

(b) if there is to be a jury, assisting their comprehension of those issues and expediting the proceedings before them,

(c) determining an application to which section 45 of the Criminal Justice Act 2003 applies,

(d) assisting the judge's management of the trial,

(e) considering questions as to the severance or joinder of charges,

(3) In a case in which it appears to a judge of the Crown Court that evidence on an indictment reveals a case of fraud of such seriousness or complexity as is mentioned in section 7 of the Criminal Justice Act 1987 (preparatory hearings in cases of serious or complex fraud)—

(a) the judge may make an order for a preparatory hearing under this section only if he is required to do so by subsection (1B) or (1C);

(b) before making an order in pursuance of either of those subsections, he must determine whether to make an order for a preparatory hearing under that section; and

(c) he is not required by either of those subsections to make an order for a preparatory hearing under this section if he determines that an order should be made for a preparatory hearing under that section;

and, in a case in which an order is made for a preparatory hearing under that section, requirements imposed by those subsections apply only if that order ceases to have effect.

(4) An order that a preparatory hearing shall be held may be made—

(a) on the application of the prosecutor,

(b) on the application of the accused or, if there is more than one, any of them, or

(c) of the judge's own motion.

46. Section 31 of the 1996 Act provides as follows:

"31. The preparatory hearing.

(1) At the preparatory hearing the judge may exercise any of the powers specified in this section.

(2) The judge may adjourn a preparatory hearing from time to time.

(3) He may make a ruling as to—

(a) any question as to the admissibility of evidence;

(b) any other question of law relating to the case.

(c) any question as to the severance or joinder of charges.

(4) He may order the prosecutor—

(a) to give the court and the accused or, if there is more than one, each of them a written statement (a case statement) of the matters falling within subsection (5);

(b) to prepare the prosecution evidence and any explanatory material in such a form as appears to the judge to be likely to aid comprehension by [a jury]and to give it in that form to the court and to the accused or, if there is more than one, to each of them;

(c) to give the court and the accused or, if there is more than one, each of them written notice of documents the truth of the contents of which ought in the prosecutor's view to be admitted and of any other matters which in his view ought to be agreed;

> (d) to make any amendments of any case statement given in pursuance of an order under paragraph (a) that appear to the judge to be appropriate, having regard to objections made by the accused or, if there is more than one, by any of them.
>
> (5) The matters referred to in subsection (4)(a) are—
>
> (a) the principal facts of the case for the prosecution;
>
> (b) the witnesses who will speak to those facts;
>
> (c) any exhibits relevant to those facts;
>
> (d) any proposition of law on which the prosecutor proposes to rely;
>
> (e) the consequences in relation to any of the counts in the indictment that appear to the prosecutor to flow from the matters falling within paragraphs (a) to (d)."

47. I was referred in the written submissions to a number of authorities on this topic, including ***R v H*** [2007] 2 AC 270; ***R v I*** [2010] 1 WLR 1125; and ***R v R, M and L*** [2013] EWCA Crim 708. However, the modern law and practice seems to me to be neatly summarised by the Lord Chief Justice in ***R v Gary Quillan and others*** [2015] EWCA Crim 538. In that case, the Lord Chief Justice said this:

> "9. This court has given guidance in a number of cases particularly in ***R v I*** [2010] 1 WLR 1125, [2010] 1 Cr App R 10 as to the circumstances in which a preparatory hearing under Part III of the 1996 Act should be conducted. In giving the judgment of the court in ***R v I***, the then Vice-President, Hughes LJ, said at paragraph 21:
>
> > "Virtually the only reason for directing such a hearing nowadays is if the judge is going to have to give a ruling which ought to be the subject of an interlocutory appeal. Such rulings are few and far between and do not extend to most rulings of law."
>
> 10. Whilst that is almost invariably the position, there may be special circumstances where a trial will be very long and very costly and where a ruling on a point of law in relation to the legal basis on which a count in the indictment is founded may determine whether or not a trial is required at all. In such a case such a point of law should be determined well before any trial starts. That is not the same thing as saying that it must be resolved in a preparatory hearing. There is a power in any case under s.40 of the 1996 Act to hold a pre-trial hearing and to decide any question of law relating to the case concerned. This

> procedure does not involve any of the technicalities which have caused some difficulty in relation to preparatory hearings and there is no interlocutory right of appeal (except where the prosecution treats any ruling as a terminating ruling)."

4.2 The Submissions

48. On behalf of the Trust, Mr Cooper QC submitted that the test in Sections 29 and 31 had been met because:

    (a) This was a serious and complex case in which there will be a lengthy trial;

    (b) The decision on the interpretation of the 2007 Act would identify the relevant issues for the benefit of the court and the jury and assist the management of the trial;

    (c) The decision on the interpretation of the 2007 Act was also a question of law relating to the case and therefore met the test under Section 31.

49. On behalf of the Crown, Mr Price QC submitted that the test in Section 29 and 31 had not been met because:

    (a) The Crown had been right as to its approach so no relevant issue arose;

    (b) The case was serious but not particularly complex and the length of trial of four weeks was not particularly long;

    (c) ***R v I*** made clear that a preparatory hearing would be beneficial in a few very limited circumstances and ***R v R*** stated that it would only arise in the case of "a very high degree of gravity";

    (d) That this case in this hearing did not meet that high test.

4.3 Analysis

50. For a variety of reasons, I am not going to designate this hearing as a preparatory hearing within the meaning of the 1996 Act. First I note that it was not designated as a preparatory hearing by Singh J when he made the order to fix it. That is of course far from determinative, but it is a useful starting point.

51. Secondly, I have not decided any issue of law. I have simply demonstrated the relatively limited effect which the 2007 Act might have in this case on the presentation of any events prior to 6 April 2008. That goes, as I have said, to the evidence which the Crown may call and the way in which they deploy it. That is not an issue of law. Accordingly, Section 31 seems to me to be irrelevant.

52. Thirdly, I have not determined any issues, either for myself or the jury. I have simply indicated a way in which the evidence might come out in relation to the events prior to (and indeed after) the commencement date of 6 April 2008. That does not seem to me to be anything other than the typical sort of case management discussion held in advance of any criminal trial. It is a long way from being a preparatory hearing.

53. As I said at the outset, this is a very sad case. It is obviously serious, because it involves the unexpected death of Mrs Cappuccini. But I do not consider that the case itself is particularly complex. The medical evidence is, I think, no more difficult to assimilate than the medical evidence in, say, a baby shaking case. A trial of four weeks is not, sadly, particularly long, certainly not for a case like this.

54. In those circumstances, I do not consider that Section 29 applies either.

55. Thus, for the reasons that I have set out, I do not designate this as a preparatory hearing under the 1996 Act. I do, however, consider that it has been extremely useful.

costs they have incurred as a result of having to file a supplemental case to answer the contentions advanced for the first time in the case for the Crown. I would not accede to this request.

Appeal allowed.

Solicitors: Solicitor of Inland Revenue; Sebastian Coleman & Co. for Wragge & Co., Birmingham.

C. T. B.

[HOUSE OF LORDS]

REGINA . . . . . RESPONDENT

AND

ADOMAKO . . . . . APPELLANT

1994 May 10, 11; June 30

Lord Mackay of Clashfern L.C., Lord Keith of Kinkel, Lord Goff of Chieveley, Lord Browne-Wilkinson and Lord Woolf

Crime—Homicide—Manslaughter—Involuntary manslaughter—Breach of duty—Appropriate test—Whether necessary to show gross negligence—Whether jury to be directed as to "recklessness"

The defendant, an anaesthetist, was acting as such during an eye operation, which involved paralysing the patient, when a tube became disconnected from a ventilator. The patient suffered a cardiac arrest and subsequently died. The defendant was convicted of the manslaughter of the patient by breach of duty.

On appeal against conviction the Court of Appeal (Criminal Division) dismissed the appeal.

On appeal by the defendant, on the question of the true legal basis of involuntary manslaughter by breach of duty:—

Held, dismissing the appeal, that in cases of manslaughter by criminal negligence involving a breach of duty the ordinary principles of the law of negligence applied to ascertain whether the defendant had been in breach of a duty of care towards the victim; that on the establishment of such breach of duty the next question was whether it caused the death of the victim, and if so, whether it should be characterised as gross negligence and therefore a crime; and that it was eminently a jury question to decide whether, having regard to the risk of death involved, the defendant's conduct was so bad in all the circumstances as to amount to a criminal act or omission (post, pp. 187B, D–E, 189G–190B).

Rex v. Bateman (1925) 19 Cr.App.R. 8, C.C.A. and *Andrews v. Director of Public Prosecutions* [1937] A.C. 576, H.L.(E.) applied.

Reg. v. Lawrence (Stephen) [1982] A.C. 510, H.L.(E.) considered.

Reg. v. Seymour (Edward) [1983] 2 A.C. 493, H.L.(E.) disapproved.

Per curiam. In cases of involuntary manslaughter it is not necessary for the trial judge in directing the jury to refer to the definition of recklessness given in *Reg. v. Lawrence* although it is perfectly open to him to use the word "reckless" in its ordinary meaning as part of his exposition of the law if he deems it appropriate in the circumstances of the particular case (post, pp. 188H–189A, G–190B).

Decision of the Court of Appeal (Criminal Division) sub nom. *Reg. v. Prentice* [1994] Q.B. 302 affirmed.

The following cases are referred to in the opinion of Lord Mackay of Clashfern L.C.:

Andrews v. Director of Public Prosecutions [1937] A.C. 576; [1937] 2 All E.R. 552, H.L.(E.)

Kong Cheuk Kwan v. The Queen (1985) 82 Cr.App.R. 18, P.C.

Reg. v. Lawrence (Stephen) [1982] A.C. 510; [1981] 2 W.L.R. 524; [1981] 1 All E.R. 974, H.L.(E.)

Reg. v. Prentice [1994] Q.B. 302; [1993] 3 W.L.R. 927; [1993] 4 All E.R. 935, C.A.

Reg. v. Seymour (Edward) [1983] 2 A.C. 493; [1983] 3 W.L.R. 349; [1983] 2 All E.R. 1058, H.L.(E.)

Reg. v. Stone [1977] Q.B. 354; [1977] 2 W.L.R. 169; [1977] 2 All E.R. 341, C.A.

Reg. v. West London Coroner, Ex parte Gray [1988] Q.B. 467; [1987] 2 W.L.R. 1020; [1987] 2 All E.R. 129, D.C.

Rex v. Bateman (1925) 19 Cr.App.R. 8, C.C.A.

The following additional cases were cited in argument:

Akerele v. The King [1943] A.C. 255; [1943] 1 All E.R. 367, P.C.

Dabholkar v. The King [1948] A.C. 221, P.C.

Elliott v. C. [1983] 1 W.L.R. 939; [1983] 2 All E.R. 1005, D.C.

Reg. v. Ball [1989] Crim.L.R. 730, C.A.

Reg. v. Caldwell [1982] A.C. 341; [1981] 2 W.L.R. 509; [1981] 1 All E.R. 961, C.A.

Reg. v. Church [1966] 1 Q.B. 59; [1965] 2 W.L.R. 1220; [1965] 2 All E.R. 72, C.C.A.

Reg. v. Governor of Holloway Prison, Ex parte Jennings [1983] 1 A.C. 624; [1982] 3 W.L.R. 450; [1982] 3 All E.R. 104, H.L.(E.)

Reg. v. Lamb [1967] 2 Q.B. 981; [1967] 3 W.L.R. 888; [1967] 2 All E.R. 1282, C.A.

Reg. v. Lowe [1973] Q.B. 702; [1973] 2 W.L.R. 481; [1973] 1 All E.R. 805, C.A.

Reg. v. Nicholls (1874) 13 Cox C.C. 75

Reg. v. Noakes (1866) 4 F. & F. 920

Reg. v. Pigg [1983] 1 W.L.R. 6; [1983] 1 All E.R. 56, H.L.(E.)

Reg. v. Reid [1992] 1 W.L.R. 793; [1992] 3 All E.R. 673, H.L.(E.)

Reg. v. Satnam S. (1983) 78 Cr.App.R. 149, C.A.

Reg. v. Stanley (unreported), 10 October 1990, Turner J.

Reg. v. Yogasakaran [1990] 1 N.Z.L.R. 399
Rex v. Long (1830) 4 C. & P. 398
Rex v. Williamson (1807) 3 C. & P. 635
Sweet v. Parsley [1970] A.C. 132; [1969] 2 W.L.R. 470; [1969] 1 All E.R. 347, H.L.(E.)

APPEAL from the Court of Appeal (Criminal Division).

This was an appeal by leave dated 23 November 1993 of the House of Lords (Lord Keith of Kinkel, Lord Goff of Chieveley and Lord Slynn of Hadley) by the defendant, John Ajare Adomako, from the judgment dated 20 May 1993 of the Court of Appeal (Criminal Division) (Lord Taylor of Gosforth C.J., Henry and Blofeld JJ.) dismissing his appeal against his conviction of manslaughter on 26 January 1990 at the Central Criminal Court before Alliott J. and a jury.

The Court of Appeal on 15 June 1993 certified pursuant to section 33(2) of the Criminal Appeal Act 1968 that a point of law was involved in its decision, namely:

> "in cases of manslaughter by criminal negligence not involving driving but involving a breach of duty is it a sufficient direction to the jury to adopt the gross negligence test set out by the Court of Appeal in the present case following *Rex v. Bateman* (1925) 19 Cr.App.R. 8 and *Andrews v. Director of Public Prosecutions* [1937] A.C. 576 without reference to the test of recklessness as defined in *Reg. v. Lawrence (Stephen)* [1982] A.C. 510 or as adapted to the circumstances of the case?"

Leave to appeal was refused.

The facts are stated in the opinion of Lord Mackay of Clashfern L.C.

Lord Williams of Mostyn Q.C. and *James Watson* for the defendant. The offence of involuntary manslaughter should have the characteristics of (i) clarity, (ii) certainty, (iii) intellectual coherence and (iv) general applicability. If these criteria are applied to the judgment of the Court of Appeal in the present case, the reasoning on which it is based is found wanting and the conviction cannot stand. The criteria can be summarised in the proposition that there must be a single test as to what constitutes involuntary manslaughter and that test should be that of recklessness. There is no logical or jurisprudential difference between cases of involuntary manslaughter caused by the driving of motor vehicles and those caused by any other means.

The modern development of the law of involuntary manslaughter has created uncertainty as to which test should be adopted and, in particular, whether gross negligence should remain at all as a substantive test: see the editorial note to *Reg. v. Ball* [1989] Crim.L.R. 730. The trial judge directed the jury that in manslaughter cases of this kind the killing must be as a result of a grossly negligent act. He emphasised that a very high degree of negligence was required before the crime could be established and he culled passages from *Rex v. Long* (1830) 4 C. & P. 398; *Rex v. Bateman* (1925) 19 Cr.App.R. 8 and *Rex v. Williamson* (1807) 3 C. & P. 635 (without naming them) to illustrate the standard to be applied. In the Court of Appeal it was contended on behalf of the defendant that the judge's summing up was deficient in that it adopted the test of gross

negligence alone, epitomised by *Rex v. Bateman*, 19 Cr.App.R. 8 and *Andrews v. Director of Public Prosecutions* [1937] A.C. 576, 583, and that it did so without reference to the test of recklessness propounded in *Reg. v. Lawrence (Stephen)* [1982] A.C. 510. It follows on the decision in *Lawrence* and subsequent authorities that to convict for involuntary manslaughter there must be recklessness or wilful knowledge of risk which might bring about serious injury or death, but nevertheless a conscious intention to take that risk. Further, "recklessness" in this context might import wilfully shutting one's mind to the known risk. The defendant argued that the manifest differences in approach adopted by the three trial judges in the three cases under appeal in *Reg. v. Prentice* [1994] Q.B. 302 illustrated the difficulty and confusion which prosecutors, judges and juries had experienced in the present type of case. It was contended therefore that there was a need for uniformity of approach by prosecuting authorities and judges and that preference ought to be given to the *Lawrence* direction as suitably adapted to the circumstances of each case.

The foregoing difficulty arises out of *Andrews v. Director of Public Prosecutions* [1937] A.C. 576 itself, for whilst apparently giving approval to *Rex v. Bateman*, 19 Cr.App.R. 8, where gross negligence was the test, Lord Atkin's speech (p. 583) also supports the proposition that recklessness will, in almost all cases, be the most useful underlying criterion.

Although the gross negligence test was adopted shortly after *Andrews* by the Privy Council in *Akerele v. The King* [1943] A.C. 255 and *Dabholkar v. The King* [1948] A.C. 221, the qualified terms in which that test was approved in *Andrews* has led recently to the authorities treating recklessness as the primary element: see *Reg. v. Stone* [1977] Q.B. 354. This trend was approved by the Privy Council in *Kong Cheuk Kwan v. The Queen* (1985) 82 Cr.App.R. 18, 26, where it was pointed out that Lord Atkin in his speech in *Andrews* clearly thought (and the Board agreed with his view) that it was better to use the word "reckless" rather than to add to the word "negligence" various possible vituperative epithets.

In *Kong Cheuk Kwan* the Board, approving the judgment of the Court of Appeal in *Reg v. Seymour (Edward)* (1983) 76 Cr.App.R. 211, 216, considered "recklessness" as the uppermost, if not the only test to apply in the context of a case, where manslaughter had been charged, arising out of a collision between two hydrofoil boats. That approach was also adopted by the Divisional Court in *Reg. v. West London Coroner, Ex parte Gray* [1988] Q.B. 467 and by Turner J. in *Reg. v. Stanley* (unreported), 10 October 1990.

Reg. v. Lawrence [1982] A.C. 510 was confined to the meaning of recklessness for the purposes of the statutory offence of "driving recklessly" under section 1 of the Road Traffic Act 1972. But the *Lawrence* definition of recklessness has since been held to apply equally to the common law offence: see *Reg. v. Governor of Holloway Prison, Ex parte Jennings* [1983] 1 A.C. 624; *Reg. v. Seymour* [1983] 2 A.C. 493, 502E–H, 504H, 506E–G and *Kong Cheuk Kwan v. The Queen*, 82 Cr.App.R. 18.

To the question whether involuntary manslaughter requires mens rea, the answer is in the affirmative. Although in *Andrews v. Director of Public Prosecutions* [1937] A.C. 576 Lord Atkin did not find connotations of mens rea helpful, he did not suggest that there was a distinction in this

A respect between the statutory and common law offences of death by dangerous driving. *Reg. v. Lawrence* [1982] A.C. 510 and *Reg. v. Reid* [1992] 1 W.L.R. 793 have held and defined mens rea in the context of the statutory motoring offences to be "recklessness" in the sense formulated by Lord Diplock in *Lawrence*, and the effect of *Reg. v. Seymour* [1983] 2 A.C. 493 and *Reg. v. Governor of Holloway Prison, Ex parte Jennings* [1983] 1 A.C. 624 is that mens rea is also required for common law motor B manslaughter.

It is difficult to see why mens rea should be required in motor manslaughter, where recklessness is usually the essential ingredient of the offence, but not in other cases of death by criminal negligence. In *Reg. v. Lamb* [1967] 2 Q.B. 981 and *Reg. v. Stone* [1977] Q.B. 354 it was emphasised that the mental element was an essential ingredient of the C offence there charged regardless of whether the test was gross negligence or recklessness. Lord Hailsham of St. Marylebone in *Reg. v. Lawrence* [1982] A.C. 510, 520D–F approved the need for some "guilty state of mind" to constitute the mens rea of all indictable offences, thus adopting the approach of Lord Reid in *Sweet v. Parsley* [1970] A.C. 132, 149G.

The criteria by which the jury are invited to determine guilt or innocence in relation to the offence of manslaughter should be clear and D unambiguous. They should explicitly encourage the jury to focus not upon the outcome of the defendant's acts or omissions but upon the mental attitude which governed the defendant's conduct. A test which adopts negligence alone as the central measure may be potentially misleading. If used by itself the term is capable of suggesting to the jury that it should be equated with negligent conduct as understood in the context of the civil E law. The jury may understand by that that no mental element is required at all. Further, merely attaching the word "gross" does not provide a mental element. The grossness of an act of negligence does not necessarily depend upon intent. The margin by which a defendant has departed from the standard of reasonable care does not imply a "guilty mind" unless and until the departure is so great, or gross, that the jury can infer that it must have been committed with a guilty state of mind. Until that point of F inference is reached the margin by which the act or omission departs from the ordinary standard of reasonable care may not be the product of guilty intent. It may not even be the product of intent at all but of other factors, for example, inexperience or panic, which are not in themselves always culpable.

The foregoing test might enable a relatively minor act of negligence G resulting in death to escape criminal liability even if it is committed by someone whose attitude is thoroughly indifferent and blameworthy. In contrast, a more striking act of negligence would automatically invite criminal prosecution regardless of the attitude of the perpetrator.

If the epithet "gross" is intended to convey to the jury a need to consider both a great degree of negligence and an abnormal attitude on the part of the accused then it requires greater elucidation. Left as it is the H phrase "gross negligence" (a) places undue emphasis upon conduct rather than upon an assessment of intent; (b) implies to the jury that they may infer "a guilty mind" simply from the fact that negligence is of a particularly high degree without offering any assistance as to how that

"guilty mind" itself can be recognised or defined; and (c) invites the jury to find guilt even in circumstances where the jury may be unsure, or may not even have considered, whether or not the defendant's state of mind is to be regarded as criminal.

A further problem with such a test is that it is inherently difficult for a jury to apply in cases involving breach of duty where the breach is committed by a skilled person and involves technical issues and professional judgments. In such a situation it is safer for the jury to judge the conduct of the accused by reference to the character of his mental attitude (about which they can form a direct judgment) rather than by reference to the degree by which his conduct fell short of a standard of competence—a standard which may in itself be difficult for the jury to fix in their minds and which may have to be judged solely through the indirect perspective of expert witnesses.

If the test is to be simply "gross negligence" it would be necessary in particular cases to remind the jury of the need to take into account the accused's state of mind when considering whether he is guilty of criminal negligence: see *Reg. v. Lamb* [1967] 2 Q.B. 981. This is unhelpful unless the characteristics of a guilty state of mind can themselves be defined in a way which assists the jury.

Mere negligence on the part of the defendant should not attract criminal liability for the offence of manslaughter until the point at which the jury either conclude that the defendant's mental attitude was actually reckless or conclude that the negligence was of such a high degree that a reckless state of mind can and must properly be inferred.

In *Andrews v. Director of Public Prosecutions* [1937] A.C. 576 Lord Atkin himself did not accept that the epithet "gross" was appropriate. He effectively rejected it in favour of "reckless." His qualification to the effect that the epithet "reckless" was probably not all embracing cannot be read as a concession that "gross" is preferable. In practice, "recklessness" as it is now understood *is* probably all embracing, at least as the basis for directing the jury in cases of manslaughter involving breach of a duty of care. In *Andrews* Lord Atkin, at p. 584, accepted that recklessness in the context of the statutory offence will almost certainly create the common law offence, and his example of circumstances where it might not apply (p. 583) can in fact be regarded as a situation where the defendant is reckless.

In the circumstances of the present case the jury should have been directed that they had to be satisfied that (a) the defendant owed a duty of care to the deceased; (b) the defendant failed in that duty in one or more of the respects alleged; (c) the defendant's failure or failures were either the cause of the deceased's death or a substantial cause; (d) at the time it was, or ought to have been, plain to the defendant that there was a risk of serious harm if he failed in his duty; (e) the defendant's state of mind was criminally culpable, that is to say, in general terms, his mental attitude amounted to either (i) a conscious or deliberate intention to run a risk which involved obvious risk of significant injury or death or (ii) indifference to, or disregard of, such a risk; and (f) in particular, in the context of the present case, the failures on the part of the defendant (namely, to respond to or remedy the disconnection and avert the risk of

A hypoxia) went far beyond a simple matter of ordinary human error or thoughtlessness but displayed or implied an attitude of mind on his part which amounted to either actual disregard of, or indifference to, that risk or to the duty itself.

In judging the seriousness and character of the failures alleged and the attitude of mind possessed by the defendant the jury must take into account all the evidence which shows how they came to arise, including B the defendant's own evidence as to how he himself perceived the situation at the time, what he did, and why he did it. Such evidence may explain or justify conduct which may, at first sight, appear to be governed by a reckless state of mind. The jury may, for example, conclude, having taken all such evidence into account, that the defendant's conduct was intended not to run the risk but rather to avert or avoid it. If so, the jury may C conclude that the defendant was not in the circumstances acting recklessly. On the other hand, the defendant's chosen course of conduct may be considered to be so bad and so unjustifiable that a mental attitude of indifference or disregard is an inescapable inference on the part of the jury whatever excuse is put forward.

A proper focus on the accused's state of mind is of vital importance in considering a count as serious as involuntary manslaughter. The D fundamental question is: what is the basis of the offence of involuntary manslaughter? The judgment of the Court of Appeal [1994] Q.B. 302, 322H–323B suggested that such states of mind may, in appropriate cases, be described in at least four ways. The list may provide helpful illustrations but they are expressly stated to be non-exhaustive examples which do not detract from the simple test and therefore do not resolve the key issue E which is whether gross negligence of itself is a sufficient direction. In fact, the examples given tend to support the wisdom of adopting recklessness as the primary criterion.

Andrews v. Director of Public Prosecutions [1937] A.C. 576 is consistent with the defendant's primary case in that *Andrews* held that, in cases of motor manslaughter "recklessness" was the most appropriate epithet and would almost always suffice. *Andrews* is also consistent with the F defendant's case in that it must now be read in the light of the decisions in *Reg. v. Seymour* [1983] 2 A.C. 493, *Reg. v. Governor of Holloway Prison, Ex parte Jennings* [1983] 1 A.C. 624, *Reg. v. Lawrence* [1982] A.C. 510 and *Reg. v. Reid* [1992] 1 W.L.R. 793, by which this House has held that (i) the ingredients of motor manslaughter at common law are the same as those for the (then existing) statutory offence of death by dangerous G driving; and (ii) the ingredients of the offence at common law including recklessness are as defined in *Lawrence* or as adapted to the circumstances of the case. Further, if the distinction drawn by the Court of Appeal between motor manslaughter and other forms of manslaughter is upheld, *Andrews* remains consistent with the defendant's case in that it related solely to the direction to be given in cases of motor manslaughter and is not binding upon cases of manslaughter by criminal negligence not H involving driving.

But the House will be invited to depart from *Andrews* if it is held that that decision (a) applies to involuntary manslaughter outside the realm of driving (b) is in conflict with the effect of the decisions in *Reg. v. Seymour*

[1983] 2 A.C. 493, *Reg. v. Governor of Holloway Prison, Ex parte Jennings* A [1983] 1 A.C. 624, *Reg. v. Lawrence* [1982] A.C. 510 and *Kong Cheuk Kwan v. The Queen*, 82 Cr.App.R. 18, and (c) is authority for the proposition that a direction referring only to "gross negligence" is sufficient.

Ann Curnow Q.C. and *Anthony Leonard* for the Crown. The range of possible duties, breaches and surrounding circumstances is so varied that it is not possible to prescribe a standard jury direction appropriate in all B cases. The judge should tailor his summing up to the circumstances of the particular case: *Reg. v. Prentice* [1994] Q.B. 302, 322H. The difficulties arising from *Reg. v. Lawrence* [1982] A.C. 510 come from putting Lord Diplock's definition of "recklessness" in that case in a straitjacket. Manslaughter caused by gross negligence is only a way of describing what in the past was involuntary manslaughter. For centuries gross negligence C was equivalent to "recklessness:" see *Reg. v. Noakes* (1866) 4 F. & F. 920 and the notes at pp. 921, 922. [Reference was also made to *Rex v. Williamson*, 3 C. & P. 635; *Rex v. Long*, 4 C. & P. 398 and *Reg. v. Nicholls* (1874) 13 Cox C.C. 75]. The concept of recklessness given its ordinary historic dictionary definition is primarily relevant to acts of *commission*: it cannot encompass all the circumstances envisaged as creating criminal responsibility. The concept of gross negligence is primarily relevant to acts D of *omission*.

Recklessness as refined by Lord Diplock in *Caldwell* and *Lawrence* requires the jury to be directed that they must be sure that the defendant's conduct caused an obvious and serious risk and that the defendant either (i) failed to give any thought to the possibility of there being any such risk or (ii) having recognised that there was such a risk, nevertheless went E on to take it. Neither test is appropriate to someone in the position of the defendant, who *failed* to act to prevent death. It was his duty, making use of his training and skill as an anaesthetist, to react in a dangerous situation. The risk was known, it was always present and he was there to minimise that risk. An anaesthetist ought to recognise when a situation has arisen which requires him to intervene and his degree of negligence has to be judged by his *failure* to act when such a situation arises. The use F of the phrase "gross inattention" was wholly suited to the role of the defendant, who had the duty as an anaesthetist to monitor the patient at all times during the operation. [Reference was made to the definition of "negligence" in the *New Shorter Oxford English Dictionary* (1993) and of "negligence" and "recklessly" in the *Oxford English Dictionary* (1933).]

The present case is one of *omission*. Lord Diplock's definition of G "recklessness" in *Lawrence* is only really applicable where the accused creates the danger or is present when the danger arises. It is nigh impossible to apply Lord Diplock's definition of recklessness to cases of omission.

In *Rex v. Bateman*, 19 Cr.App.R. 8 a distinction was drawn for the first time between cases where death is alleged to have been caused by indolence or carelessness and cases where death is alleged to have been H caused by recklessness. As to the first category, where a qualified man holding himself out as possessing special skill and knowledge was consulted by a patient, it is no defence to show that he was diligent in

attendance if the patient was killed by his gross negligence and unskilfulness, and where incompetence is alleged the unqualified practitioner cannot claim to be measured by any lower standard than the qualified person. As to the second category, cases of alleged recklessness, juries are likely to distinguish between qualified and unqualified practitioners. A qualified person who undertakes a case beyond his powers may be reckless. Further, a qualified person who subjects his patient to a reckless experiment may be considered to have acted recklessly, and an unqualified person may be reckless in undertaking treatment. "Recklessness" was given its ordinary meaning, not the definition it has obtained since *Lawrence* and *Caldwell.*

In *Bateman* it was held that to support an indictment for manslaughter the prosecution must prove the matters necessary to establish civil liability (save for pecuniary loss) and in addition must satisfy the jury that the negligence *or* incompetence of the accused went beyond a mere matter of compensation and showed such a disregard for the life and safety of others as to amount to a crime against the state and deserving of punishment. The case concerned a medical practitioner competent to deal with the medical condition of the deceased. The direction of the trial judge, who used epithets such as "gross", "wicked" and "culpable," was approved and the court emphasised the need for the jury to be able to distinguish between mistake and error of judgment (where liability does not arise) and carelessness and incompetence. Had the court been concerned with one of the situations outlined under the second category, then "recklessness" would have more closely described the standard that they should have examined. *Bateman* has not been overruled and has frequently been authoritatively referred to with approval, notably in *Andrews v. Director of Public Prosecutions* [1937] A.C. 576, a decision of this House which has never been disapproved of.

The following conclusions may be drawn from *Andrews*. (a) The House was only considering manslaughter from the point of view of an unintentional killing caused by negligence (p. 581). (b) It approved *Bateman* without finding the connotations of mens rea helpful in distinguishing between degrees of negligence. (c) Cases of manslaughter in driving motor cars are but instances of a general rule applicable to all charges of homicide by negligence. (d) Of all the epithets that can be applied "reckless" most nearly covers the case of causing death by driving, but it is not all-embracing. (e) The decision draws a distinction between the degree of negligence required to be proved in the case of (i) manslaughter (requiring a high degree of negligence as indicated in *Bateman*) and (ii) dangerous driving, in which the degree of negligence is not necessarily as high.

It must be borne in mind that one is here catering for juries who must understand what the law is concerning involuntary manslaughter. In *Reg. v. Reid* [1992] 1 W.L.R. 793 the House held that the ipsissima verba of the test laid down in *Reg. v. Lawrence* [1982] A.C. 510 should not necessarily be the only statement on the law given to the jury. But at the date of the present trial in January 1990 the trial judge deemed it only safe if "recklessness" was to be the test to use the exact language of that test. In the circumstances he cannot be criticised for so doing. The defendant

might not be caught by the *Lawrence* direction. The question then arises: A would the public be offended by a verdict of "Not Guilty" in the circumstances of the case? It is extremely difficult, if not now impossible, to apply the *Lawrence* test to a case of omission. Criminal negligence is more easily comprehensible than the concept of recklessness.

The Crown is not seeking to create a crime where the accused is to be judged by some objective standard. The test to be applied is one of gross negligence and one takes into account the accused's individual B circumstances in deciding whether the negligence constituted *gross* negligence. The objective standard is applied to the *negligence alone*. This is the element in the *Caldwell/Lawrence* test (see [1982] A.C. 341) which the jury has to apply. They do not have to go on to consider whether the risk taken by the accused would have been obvious to the reasonably prudent person. The harshness of applying the *Caldwell* test [1982] A.C. C 341 in all circumstances is exemplified by *Elliott v. C.* [1983] 1 W.L.R. 939. As to the application of the gross negligence test in other jurisdictions, see The Law Commission, Consultation Paper, No. 135. Civil Law, Involuntary Manslaughter, paras. 3.42–3.46. There may be cases in which the term "reckless" is suited to the circumstances of the accused: see *Reg. v. Church* [1966] 1 Q.B. 59; *Reg. v. Lowe* [1973] Q.B. 702; *Reg. v. Stone* [1977] Q.B. 354 and *Reg. v. West London Coroner, Ex parte Gray* [1988] D Q.B. 467.

There remains the question whether the test of gross negligence has survived the decisions in *Reg. v. Lawrence* [1982] A.C. 510; *Reg. v. Caldwell* [1982] A.C. 341; *Reg. v. Seymour* [1983] 2 A.C. 493; *Reg. v. Reid* [1992] 1 W.L.R. 793 and *Kong Cheuk Kwan v. The Queen*, 82 Cr.App.R. 18. It is to be observed that neither *Caldwell* nor *Lawrence* dealt with E manslaughter. They were concerned with the statutory offences of arson and reckless driving respectively, defining in each case the appropriate test when the statute used the word "reckless." It is important to distinguish *Reg. v. Seymour* [1983] 2 A.C. 493, which decided that the ingredients of the two offences of causing death by reckless driving and motor manslaughter were the same. But the observations of Lord Roskill (p. 506) that "'Recklessness' should today be given the same meaning in relation F to all offences which involve 'recklessness' as one of the elements unless Parliament has otherwise ordained," was obiter: see the terms of the certified question, at p. 505B. Moreover, recklessness in the Sexual Offences Act 1976 has a different meaning, requiring a subjective approach: see *Reg. v. Pigg* [1983] 1 W.L.R. 6 and *Reg. v. Satnam S.* (1983) 78 Cr.App.R. 149. In *Kong Cheuk Kwan v. The Queen*, 82 Cr.App.R. 18, 25 G Lord Roskill limited what he had said in *Seymour* to the status of guidance to prosecutors in considering which charge to bring.

Gross negligence is a simple concept for the man in the street to understand. It has general applicability and acceptability. The *Caldwell/Lawrence* test is not appropriate in cases of breach of duty where a failure is alleged and indeed is unworkable in omission cases and not helpful in commission cases. The phrase that should be used to juries is H "culpable" or "gross" negligence in a direction relating to involuntary manslaughter, the grossness being measured by the defendant's reaction to the situation in which he found himself. [Reference was also made to

A *Akerele v. The King* [1943] A.C. 255; *Dabholkar v. The King* [1948] A.C. 221; *Reg. v. Prentice* [1994] Q.B. 302, 323 and *Reg. v. Yogasakaran* [1990] 1 N.Z.L.R. 399.]

Lord Williams of Mostyn Q.C. replied.

Their Lordships took time for consideration.

B

30 June. LORD MACKAY OF CLASHFERN L.C. My Lords, this is an appeal brought with the leave of your Lordships' House granted on 23 November 1993 from an order of Her Majesty's Court of Appeal (Criminal Division) (Lord Taylor of Gosforth C.J., Henry and Blofeld JJ.) whereby the appellant's appeal against conviction for manslaughter was dismissed.

C The conviction arose out of the conduct of an eye operation carried out at the Mayday Hospital, Croydon on 4 January 1987. The appellant was, during the latter part of that operation, the anaesthetist in charge of the patient.

The operation was carried out by two surgeons supported by a team of five nurses and a theatre sister. Anaesthesia commenced at about 9.45 a.m. The patient was paralysed by injection of a drug and an D endotracheal tube was inserted to enable the patient to breathe by mechanical means. At the start of the operation the anaesthetist was Dr. Said, a registrar. An operating department assistant was also present to help him. At about 10.30 a.m. there was a changeover of anaesthetists. The appellant was called to attend and take Dr. Said's place following which both Dr. Said and his assistant departed to deal with another E operation elsewhere in the hospital. Another assistant was called to attend but did not arrive until later.

At approximately 11.05 a.m. a disconnection occurred at the endotracheal tube connection. The supply of oxygen to the patient ceased and this led to cardiac arrest at 11.14 a.m. During this period the appellant failed to notice or remedy the disconnection.

F The appellant first became aware that something was amiss when an alarm sounded on the Dinamap machine, which monitors the patient's blood pressure. From the evidence it appears that some $4\frac{1}{2}$ minutes would have elapsed between the disconnection and the sounding of this alarm. When this alarm sounded the appellant responded in various ways by checking the equipment and by administering atropine to raise the patient's pulse. But at no stage before the cardiac arrest did he check G the integrity of the endotracheal tube connection. The disconnection itself was not discovered until after resuscitation measures had been commenced.

For the prosecution it was alleged that the appellant was guilty of gross negligence in failing to notice or respond appropriately to obvious signs that a disconnection had occurred and that the patient had ceased to breathe. In particular the prosecution alleged that the appellant had H failed to notice at various stages during the period after disconnection and before the arrest either occurred or became inevitable that the patient's chest was not moving, the dials on the mechanical ventilating machine were not operating, the disconnection in the endotracheal tube, that the

alarm on the ventilator was not switched on and that the patient was becoming progressively blue. Further the prosecution alleged that the appellant had noticed but failed to understand the correct significance of the fact that during this period the patient's pulse had dropped and the patient's blood pressure had dropped.

Two expert witnesses gave evidence for the prosecution. Professor Payne described the standard of care as "abysmal" while Professor Adams stated that in his view a competent anaesthetist should have recognised the signs of disconnection within 15 seconds and that the appellant's conduct amounted to "a gross dereliction of care."

On behalf of the appellant it was conceded at his trial that he had been negligent. The issue was therefore whether his conduct was criminal.

The expert witness called on behalf of the appellant at his trial was Dr. Monks. His evidence conceded that the appellant ought to have noticed the disconnection. But in his view there were factors which mitigated this failure. He considered that another independent problem either occurred or could have occurred before or at the same time as the disconnection which distracted the appellant's attention and activities. This problem would in his view have caused the patient's blood pressure to drop and may either have been a reaction to the drug being used to paralyse the patient or alternatively may have been caused by an ocular cardiac reflex.

The appellant himself said in evidence that when the alarm sounded on the Dinamap machine his first thought was that the machine itself was not working properly. Having carried out checks on the machine he then thought that the patient had suffered an ocular cardiac reflex for which he administered atropine in two successive doses. Further attempts to administer atropine by intravenous drip and to check the patient's blood pressure followed until the cardiac arrest occurred. It had never occurred to him that a disconnection had taken place. He stated in evidence that "after things went wrong I think I did panic a bit."

In relation to the appellant's actions during this period Professor Payne had conceded during cross-examination that "given that Dr. Adomako misled himself the efforts he made were not unreasonable." The period to which this evidence referred was obviously the period after the alarm had sounded on the Dinamap machine which was, as I have said, apparently some $4\frac{1}{2}$ minutes after the disconnection occurred.

The jury convicted the appellant of manslaughter by a majority of 11 to 1. The Court of Appeal (Criminal Division) dismissed the appellant's appeal against conviction but certified that a point of law of general public importance was involved in the decision to dismiss the appeal, namely:

> "in cases of manslaughter by criminal negligence not involving driving but involving a breach of duty is it a sufficient direction to the jury to adopt the gross negligence test set out by the Court of Appeal in the present case following *Rex v. Bateman* (1925) 19 Cr.App.R. 8 and *Andrews v. Director of Public Prosecutions* [1937] A.C. 576, without reference to the test of recklessness as defined in *Reg. v. Lawrence (Stephen)* [1982] A.C. 510 or as adapted to the circumstances of the case?"

A The decision of the Court of Appeal is reported sub nom. *Reg. v. Prentice* [1994] Q.B. 302 along with a number of other cases involving similar questions of law. The Court of Appeal held that except in cases of motor manslaughter the ingredients which had to be proved to establish an offence of involuntary manslaughter by breach of duty were the existence of the duty, a breach of the duty which had caused death and gross negligence which the jury considered to justify a criminal conviction; B the jury might properly find gross negligence on proof of indifference to an obvious risk of injury to health or of actual foresight of the risk coupled either with a determination nevertheless to run it or with an intention to avoid it but involving such a high degree of negligence in the attempted avoidance as the jury considered justified conviction or of inattention or failure to advert to a serious risk going beyond mere C inadvertence in respect of an obvious and important matter which the defendant's duty demanded he should address; and that, in the circumstances, the appeals of the two junior doctors and the electrician would be allowed and the appeal of the anaesthetist, namely Dr. Adomako, would be dismissed. The reason that the Court of Appeal excepted the cases of motor manslaughter and their formulation of the law was the decision of this House in *Reg. v. Seymour (Edward)* [1983] D 2 A.C. 493 in which it was held that where manslaughter was charged and the circumstances were that the victim was killed as a result of the reckless driving of the defendant on a public highway, the trial judge should give the jury the direction which had been suggested in *Reg. v. Lawrence (Stephen)* [1982] A.C. 510 but that it was appropriate also to point out that in order to constitute the offence of manslaughter the risk of death E being caused by the manner of the defendant's driving must be very high.

In opening his very cogent argument for the appellant before your Lordships, counsel submitted that the law in this area should have the characteristics of clarity, certainty, intellectual coherence and general applicability and acceptability. For these reasons he said the law applying to involuntary manslaughter generally should involve a universal test and that test should be the test already applied in this House to motor F manslaughter. He criticised the concept of gross negligence which was the basis of the judgment of the Court of Appeal submitting that its formulation involved circularity, the jury being told in effect to convict of a crime if they thought a crime had been committed and that accordingly using gross negligence as the conceptual basis for the crime of involuntary manslaughter was unsatisfactory and the court should apply the law laid G down in *Seymour* [1983] 2 A.C. 493 generally to all cases of involuntary manslaughter or at least use this as the basis for providing general applicability and acceptability.

Like the Court of Appeal your Lordships were treated to a considerable review of authority. I begin with *Rex v. Bateman*, 19 Cr.App.R. 8 and the opinion of Lord Hewart C.J., where he said, at pp. 10–11:

H

> "In expounding the law to juries on the trial of indictments for manslaughter by negligence, judges have often referred to the distinction between civil and criminal liability for death by negligence. The law of criminal liability for negligence is conveniently explained in that way. If A has caused the death of B by alleged negligence,

then, in order to establish civil liability, the plaintiff must prove (in addition to pecuniary loss caused by the death) that A owed a duty to B to take care, that that duty was not discharged, and that the default caused the death of B. To convict A of manslaughter, the prosecution must prove the three things above mentioned and must satisfy the jury, in addition, that A's negligence amounted to a crime. In the civil action, if it is proved that A fell short of the standard of reasonable care required by law, it matters not how far he fell short of that standard. The extent of his liability depends not on the degree of negligence, but on the amount of damage done. In a criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be mens rea."

Later he said, at pp. 11–12:

"In explaining to juries the test which they should apply to determine whether the negligence, in the particular case, amounted or did not amount to a crime, judges have used many epithets, such as 'culpable,' 'criminal,' 'gross,' 'wicked,' 'clear,' 'complete.' But, whatever epithet be used and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment."

After dealing with a number of authorities Lord Hewart C.J. went on, at pp. 12–13:

"The law as laid down in these cases may be thus summarised: If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward. It is for the judge to direct the jury what standard to apply and for the jury to say whether that standard has been reached. The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned. If the patient's death has been caused by the defendant's indolence or carelessness, it will not avail to show that he had sufficient knowledge; nor will it avail to prove that he was diligent in attendance, if the patient has been killed by his gross ignorance and unskilfulness. No further observation need be made with regard to cases where the death is alleged to have been caused by indolence or carelessness. As regards cases where incompetence is alleged, it is only necessary to say that the unqualified practitioner cannot claim to be measured by

any lower standard than that which is applied to a qualified man. As regards cases of alleged recklessness, juries are likely to distinguish between the qualified and the unqualified man. There may be recklessness in undertaking the treatment and recklessness in the conduct of it. It is, no doubt, conceivable that a qualified man may be held liable for recklessly undertaking a case which he knew, or should have known, to be beyond his powers, or for making his patient the subject of reckless experiment. Such cases are likely to be rare. In the case of the quack, where the treatment has been proved to be incompetent and to have caused the patient's death, juries are not likely to hesitate in finding liability on the ground that the defendant undertook, and continued to treat, a case involving the gravest risk to his patient, when he knew he was not competent to deal with it, or would have known if he had paid any proper regard to the life and safety of his patient."

"The foregoing observations deal with civil liability. To support an indictment for manslaughter the prosecution must prove the matters necessary to establish civil liability (except pecuniary loss), and, in addition, must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment."

Next I turn to *Andrews v. Director of Public Prosecutions* [1937] A.C. 576 which was a case of manslaughter through the dangerous driving of a motor car. In a speech with which all the other members of this House who sat agreed, Lord Atkin said, at pp. 581–582:

"of all crimes manslaughter appears to afford most difficulties of definition, for it concerns homicide in so many and so varying conditions. From the early days when any homicide involved penalty the law has gradually evolved 'through successive differentiations and integrations' until it recognises murder on the one hand, based mainly, though not exclusively, on an intention to kill, and manslaughter on the other hand, based mainly, though not exclusively, on the absence of intention to kill but with the presence of an element of 'unlawfulness' which is the elusive factor. In the present case it is only necessary to consider manslaughter from the point of view of an unintentional killing caused by negligence, that is, the omission of a duty to take care. I do not propose to discuss the development of this branch of the subject as treated in the successive treatises of Coke, Hale, Foster and East and in the judgments of the courts to be found either in directions to juries by individual judges or in the more considered pronouncements of the body of judges which preceded the formal Court of Crown Cases Reserved. Expressions will be found which indicate that to cause death by any lack of due care will amount to manslaughter; but as manners softened and the law became more humane a narrower criterion appeared. After all, manslaughter is a felony, and was capital, and men shrank from attaching the serious consequences of a conviction for felony to

results produced by mere inadvertence. The stricter view became apparent in prosecutions of medical men or men who professed medical or surgical skill for manslaughter by reason of negligence. As an instance I will cite *Rex v. Williamson* (1807) 3 C. & P. 635 where a man who practised as an accoucheur, owing to a mistake in his observation of the actual symptoms, inflicted on a patient terrible injuries from which she died. 'To substantiate that charge'—namely, manslaughter—Lord Ellenborough said, 'the prisoner must have been guilty of criminal misconduct, arising either from the grossest ignorance or the most criminal inattention.' The word 'criminal' in any attempt to define a crime is perhaps not the most helpful: but it is plain that the Lord Chief Justice meant to indicate to the jury a high degree of negligence. So at a much later date in *Rex v. Bateman*, 19 Cr.App.R. 8 a charge of manslaughter was made against a qualified medical practitioner in similar circumstances to those of *Williamson's* case."

Lord Atkin then referred to the judgment of Lord Hewart C.J. from which I have already quoted and went on, at p. 583:

"Here again I think with respect that the expressions used are not, indeed they were probably not intended to be, a precise definition of the crime. I do not myself find the connotations of mens rea helpful in distinguishing between degrees of negligence, nor do the ideas of crime and punishment in themselves carry a jury much further in deciding whether in a particular case the degree of negligence shown is a crime and deserves punishment. But the substance of the judgment is most valuable, and in my opinion is correct. In practice it has generally been adopted by judges in charging juries in all cases of manslaughter by negligence, whether in driving vehicles or otherwise. The principle to be observed is that cases of manslaughter in driving motor cars are but instances of a general rule applicable to all charges of homicide by negligence. Simple lack of care such as will constitute civil liability is not enough: for purposes of the criminal law there are degrees of negligence: and a very high degree of negligence is required to be proved before the felony is established. Probably of all the epithets that can be applied 'reckless' most nearly covers the case. It is difficult to visualise a case of death caused by reckless driving in the connotation of that term in ordinary speech which would not justify a conviction for manslaughter: but it is probably not all-embracing, for 'reckless' suggests an indifference to risk whereas the accused may have appreciated the risk and intended to avoid it and yet shown such a high degree of negligence in the means adopted to avoid the risk as would justify a conviction. If the principle of *Bateman's* case, 19 Cr.App.R. 8 is observed it will appear that the law of manslaughter has not changed by the introduction of motor vehicles on the road. Death caused by their negligent driving, though unhappily much more frequent, is to be treated in law as death caused by any other form of negligence: and juries should be directed accordingly."

In my opinion the law as stated in these two authorities is satisfactory as providing a proper basis for describing the crime of involuntary manslaughter. Since the decision in *Andrews* was a decision of your Lordships' House, it remains the most authoritative statement of the present law which I have been able to find and although its relationship to *Reg. v. Seymour* [1983] 2 A.C. 493 is a matter to which I shall have to return, it is a decision which has not been departed from. On this basis in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.

It is true that to a certain extent this involves an element of circularity, but in this branch of the law I do not believe that is fatal to its being correct as a test of how far conduct must depart from accepted standards to be characterised as criminal. This is necessarily a question of degree and an attempt to specify that degree more closely is I think likely to achieve only a spurious precision. The essence of the matter which is supremely a jury question is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.

My Lords, the view which I have stated of the correct basis in law for the crime of involuntary manslaughter accords I consider with the criteria stated by counsel although I have not reached the degree of precision in definition which he required, but in my opinion it has been reached so far as practicable and with a result which leaves the matter properly stated for a jury's determination.

My Lords, in my view the law as stated in *Reg. v. Seymour* [1983] 2 A.C. 493 should no longer apply since the underlying statutory provisions on which it rested have now been repealed by the Road Traffic Act 1991. It may be that cases of involuntary motor manslaughter will as a result become rare but I consider it unsatisfactory that there should be any exception to the generality of the statement which I have made, since such exception, in my view, gives rise to unnecessary complexity. For example in *Kong Cheuk Kwan v. The Queen* (1985) 82 Cr.App.R. 18 it would give rise to unnecessary differences between the law applicable to those navigating vessels and the lookouts on the vessels.

I consider it perfectly appropriate that the word "reckless" should be used in cases of involuntary manslaughter, but as Lord Atkin put it "in the ordinary connotation of that word." Examples in which this was done, to my mind, with complete accuracy are *Reg. v. Stone* [1977] Q.B. 354 and *Reg. v. West London Coroner, Ex parte Gray* [1988] Q.B. 467.

In my opinion it is quite unnecessary in the context of gross negligence to give the detailed directions with regard to the meaning of the word "reckless" associated with *Reg. v. Lawrence* [1982] A.C. 510. The decision of the Court of Appeal (Criminal Division) in the other cases with which they were concerned at the same time as they heard the appeal in this case indicates that the circumstances in which involuntary manslaughter has to be considered may make the somewhat elaborate and rather rigid directions inappropriate. I entirely agree with the view that the circumstances to which a charge of involuntary manslaughter may apply are so various that it is unwise to attempt to categorise or detail specimen directions. For my part I would not wish to go beyond the description of the basis in law which I have already given.

In my view the summing up of the judge in the present case was a model of clarity in analysis of the facts and in setting out the law in a manner which was readily comprehensible by the jury. The summing up was criticised in respect of the inclusion of the following passage:

> "Of course you will understand it is not for every humble man of the profession to have all that great skill of the great men in Harley Street but, on the other hand, they are not allowed to practise medicine in this country unless they have acquired a certain amount of skill. They are bound to show a reasonable amount of skill according to the circumstances of the case, and you have to judge them on the basis that they are skilled men, but not necessarily so skilled as more skilful men in the profession, and you can only convict them criminally if, in your judgment, they fall below the standard of skill which is the least qualification which any doctor should have. You should only convict a doctor of causing a death by negligence if you think he did something which no reasonably skilled doctor should have done."

The criticism was particularly of the latter part of this quotation in that it was open to the meaning that if the defendant did what no reasonably skilled doctor should have done it was open to the jury to convict him of causing death by negligence. Strictly speaking this passage is concerned with the statement of a necessary condition for a conviction by preventing a conviction unless that condition is satisfied. It is incorrect to treat it as stating a sufficient condition for conviction. In any event I consider that this passage in the context was making the point forcefully that the defendant in this case was not to be judged by the standard of more skilled doctors but by the standard of a reasonably competent doctor. There were many other passages in the summing up which emphasised the need for a high degree of negligence if the jury were to convict and read in that context I consider that the summing up cannot be faulted.

For these reasons I am of the opinion that this appeal should be dismissed and that the certified question should be answered by saying:

> "In cases of manslaughter by criminal negligence involving a breach of duty, it is a sufficient direction to the jury to adopt the gross negligence test set out by the Court of Appeal in the present case following *Rex v. Bateman*, 19 Cr.App.R. 8 and *Andrews v. Director*

of Public Prosecutions [1937] A.C. 576 and that it is not necessary to refer to the definition of recklessness in *Reg. v. Lawrence* [1982] A.C. 510, although it is perfectly open to the trial judge to use the word 'reckless' in its ordinary meaning as part of his exposition of the law if he deems it appropriate in the circumstances of the particular case."

We have been referred to the Consultation Paper by the Law Commission on Criminal Law, Involuntary Manslaughter (1994) (Law Com. No. 135), and we have also been referred to a number of standard textbooks. I have also had the opportunity of considering the note on *Reg. v. Prentice* by Sir John Smith [1994] Crim.L.R. 292 since the hearing was completed. While I have not referred to these in detail I have derived considerable help in seeking to formulate my view as a result of studying them.

I have reached the same conclusion on the basic law to be applied in this case as did the Court of Appeal. Personally I would not wish to state the law more elaborately than I have done. In particular I think it is difficult to take expressions used in particular cases out of the context of the cases in which they were used and enunciate them as if applying generally. This can I think lead to ambiguity and perhaps unnecessary complexity. The task of trial judges in setting out for the jury the issues of fact and the relevant law in cases of this class is a difficult and demanding one. I believe that the supreme test that should be satisfied in such directions is that they are comprehensible to an ordinary member of the public who is called to sit on a jury and who has no particular prior acquaintance with the law. To make it obligatory on trial judges to give directions in law which are so elaborate that the ordinary member of the jury will have great difficulty in following them, and even greater difficulty in retaining them in his memory for the purpose of application in the jury room, is no service to the cause of justice. The experienced counsel who assisted your Lordships in this appeal indicated that as a practical matter there was a danger in over elaboration of definition of the word "reckless." While therefore I have said in my view it is perfectly open to a trial judge to use the word "reckless" if it appears appropriate in the circumstances of a particular case as indicating the extent to which a defendant's conduct must deviate from that of a proper standard of care, I do not think it right to require that this should be done and certainly not right that it should incorporate the full detail required in *Lawrence*.

LORD KEITH OF KINKEL. My Lords, for the reasons given in the speech of my noble and learned friend, the Lord Chancellor, which I have read in draft and with which I agree, I, too, would dismiss the appeal and answer the certified question as he has proposed.

LORD GOFF OF CHIEVELEY. My Lords, for the reasons given in the speech of my noble and learned friend, the Lord Chancellor, which I have read in draft and with which I agree, I, too, would dismiss the appeal and answer the certified question as he has proposed.

LORD BROWNE-WILKINSON. My Lords, for the reasons given in the speech of my noble and learned friend, the Lord Chancellor, which I have read in draft and with which I agree, I, too, would dismiss the appeal and answer the certified question as he has proposed.

LORD WOOLF. My Lords, I have had the advantage of reading in draft the speech of my noble and learned friend, the Lord Chancellor, and with which I agree, I, too, would dismiss the appeal and answer the certified question as he has proposed.

Appeal dismissed.
No order as to costs.

Solicitors: Bindman & Partners; Crown Prosecution Service Headquarters.

J. A. G.

[PRIVY COUNCIL]

RED SEA INSURANCE CO. LTD. . . . . APPELLANT

AND

BOUYGUES S.A. AND OTHERS . . . . . RESPONDENTS

[APPEAL FROM THE COURT OF APPEAL OF HONG KONG]

1994 Jan. 24, 25, 26;
July 18

Lord Keith of Kinkel,
Lord Slynn of Hadley, Lord Woolf,
Lord Lloyd of Berwick and Lord Nolan

Conflict of Laws—Tort—Choice of law—Insurance policy covering building project abroad—Insurer's counterclaim—Insurer seeking to rely on direct cause of action permissible under lex loci delicti but not by lex fori—Whether lex loci delicti exclusively applicable to insurer's claim

The plaintiffs brought an action in Hong Kong against the defendant, an insurance company incorporated in Hong Kong but with its head office in Saudi Arabia, claiming to be indemnified under an insurance policy issued by the defendant for loss and expense incurred in relation to a building project in Saudi Arabia. By its counterclaim against P.C.G., a consortium which comprised 10 of the plaintiffs, the defendant alleged that P.C.G. had supplied faulty precast concrete prime building units

R. v REBELO

COURT OF APPEAL (CRIMINAL DIVISION)

President of the Queen's Bench Division (Dame Victoria Sharp), Mr Justice William Davis and Mr Justice Picken: 17 November 2020; 8 March 2021

[2021] EWCA Crim 306; [2021] 2 Cr. App. R. 3

Breach of duty of care; Causation; Chemicals; Food supplements; Jury directions; Manslaughter by gross negligence; Summing up

H1 *Homicide—Gross negligence manslaughter—Defendant selling on the internet food supplement to promote weight loss—Toxic effects of product known to defendant—Victim of offence becoming addicted to product, overdosing and dying as a result—Issue of causation of death involving consideration of whether victim's decision to ingest drug free, informed and voluntary—Proper direction to jury and whether prosecution required to surmount additional hurdle of establishing that victim's decision "eclipsed" any grossly negligent breach of the duty of care*

H2 The defendant ran a business selling on the internet the chemical, Dinitrophenol (DNP), a food supplement claimed to promote weight loss and from the sale of which large profits were to be made. DNP had not been licensed as a medicinal drug. There had been no adequate research into its use and therefore there was no reliable evidence on which to base dosing recommendations. The toxic effects of the drug were known to include kidney and liver failure and cardiac arrest. There had been reported deaths in the UK resulting from the ingestion of DNP. Both Public Health England and the Food Standards Agency had published warnings in respect of the dangers of using DNP. The defendant was fully aware of the risks and public concern relating to DNP and took active steps to disguise his activities by using various internet identities. Having encountered DNP on the defendant's website and having purchased a quantity of pills a young female suffering from depression, bulimia nervosa and emotionally unstable personality disorder with a history of overdosing on paracetamol and taking cocaine, began to use DNP but was unable to control that use despite being aware that it was causing her harm and despite warnings from her GP, social worker and friends of the dangers and potential consequences of taking DNP. After consuming a grossly excessive quantity of DNP she suffered cardiac arrest and died. The defendant was charged and convicted of unlawful act manslaughter and gross negligence manslaughter but the convictions were quashed on appeal and a retrial was ordered on the charge of gross negligence manslaughter only. At the retrial the prosecution case was that the ingestion of DNP was the substantial cause of the victim's death and that the supply of the drug for human consumption constituted a gross breach of the duty

of care owed to the victim, crossing the criminal threshold in circumstances which created an obvious and serious risk of death, The defence case was that the victim was an autonomous woman who had made a foolish decision in the exercise of her free will and killed herself, and that there was insufficient evidence that DNP created an obvious and serious risk of death, the only risk being when either there was an overdose or because there was a break in the chain of causation as a consequence of the voluntary (that was to say free, informed and deliberate) act of the deceased herself which was outside the range of responses which might be expected from a victim in this situation and therefore not reasonably foreseeable. The prosecution argued that the victim's free will was fettered and that she was coerced by the effect of her condition and the effect of the DNP so that her ability to exercise free and informed consent was compromised. In quashing the conviction for gross negligence manslaughter the Court of Appeal had suggested the terms in which a jury might be directed on the issue of a fully informed and voluntary decision, which included that they should ask whether the victim's appreciation of the risk to her health and life by taking the quantity that she did "eclipsed the defendant's grossly negligent breach of the duty of care". The defendant was convicted and, with the leave of the single judge, appealed against that conviction on the ground that the jury were misdirected by the omission of the judge to direct the jury to consider whether the actions of the victim "eclipsed" the defendant's grossly negligent breach of the duty of care. It was submitted that even if the jury concluded that the decision of the victim was not fully free and voluntary they still had to assess whether the decision to take the amount of DNP that she did "eclipsed" the defendant's gross negligence.

H3 **Held,** dismissing the appeal, that the submission based on what had been suggested by the Court of Appeal as an appropriate jury direction was misconceived because what had been said was suggestive only, not prescriptive. The passage in question was not authority for the proposition that, before the jury could safely convict, the prosecution were required to surmount the further hurdle suggested. The purpose of the passage was to explain the requirement that the breach of duty had to be a substantial and operative cause of death. The breach of duty would not be a cause of death if the victim might have made a fully free, voluntary and informed decision and the reference to "eclipsing" simply expanded on the term "fully free, voluntary and informed" and did not add an extra element. What mattered was the substance and correctness of the legal directions, not the use of the particular verb. From the summing-up taken as a whole the jury would have had in mind that it was for them to consider the significance of the fact that the victim took as much of the DNP as she did, as part of the balancing exercise which their assessment of the issue of causation required (post, [32]–[39], [54]).

H4 *R. v Rebelo* [2019] EWCA Crim 633 explained

H5 (For manslaughter by gross negligence, see *Archbold* 2021, para.19-122 and following.)

H6 **Additional cases referred to in the judgment of the court:**

R. v Kai-Whitewind [2005] EWCA Crim 1092; [2005] 2 Cr. App. R. 31

R. v Kennedy (No.2) [2007] UKHL 38; [2008] 1 Cr. App. R. 19; [2008] 1 A.C. 269; [2007] 3 W.L.R. 612

R. v Ulcay [2007] EWCA Crim 2379; [2008] 1 Cr. App. R. 27; [2008] 1 W.L.R. 1209

Appeal against conviction

H7 On 27 June 2018, in the Inner London Crown Court (Judge Jeremy Donne QC), the defendant, Bernard Rebelo, was convicted of unlawful act manslaughter, gross negligence manslaughter and placing an unsafe food on the market, contrary to art.14 of Regulation (EC) 178/2002 and reg.19 of the Food Safety and Hygiene (England) Regulations 2013 (SI 2013/2996). He was sentenced to seven years' imprisonment for gross negligence manslaughter and to 18 months' imprisonment (concurrent) for the offence of breaching the food safety regulations. No separate penalty was imposed for the offence of unlawful act manslaughter. On 11 April 2019 the defendant's appeal against conviction of the manslaughter offences was allowed and a re-trial was ordered on the charge of gross negligence manslaughter: *R. v Rebelo* [2019] EWCA Crim 633 (Sir Brian Leveson P, William Davis and Murray JJ). On 10 March 2020, the defendant was convicted after a re-trial at the Central Criminal Court (Whipple J) of gross negligence manslaughter. On 11 March 2020, before the same court, he was sentenced to seven years' imprisonment. He appealed against that conviction.

H8 The facts and grounds of appeal appear in the judgment of the court.

H9 *John Burton QC* (assigned by the Registrar of Criminal Appeals) for the defendant. *Richard Barraclough QC* and *Gordon Menzies* (instructed by the Crown Prosecution Service, Appeals Unit) for the Crown.

The court took time for consideration.

DAME VICTORIA SHARP P:

Introduction

1 On 27 June 2018, at the Crown Court sitting at Inner London, the defendant was convicted after, a trial before Judge Jeremy Donne QC and a jury, of unlawful act manslaughter, gross negligence manslaughter and placing an unsafe food on the market, contrary to art.14 of Regulation 178/2002 and reg.19 of the Food Safety and Hygiene (England) Regulations 2017. He was sentenced to seven years' imprisonment for gross negligence manslaughter and to 18 months' imprisonment (concurrent) for the offence of breaching the food safety regulations. No separate penalty was imposed for the offence of unlawful act manslaughter.

2 On 11 April 2019 his appeal against his conviction for the manslaughter offences was allowed and a re-trial was ordered on the charge of gross negligence manslaughter: see *R. v Rebelo* [2019] EWCA Crim 633 (Sir Brian Leveson P, William Davis and Murray JJ).

3 On 10 March 2020, the defendant was convicted after a re-trial at the Central Criminal Court, before Whipple J and a jury, of gross negligence manslaughter. On 11 March 2020, before the same court, he was sentenced to seven years' imprisonment. He now appeals against that conviction with limited leave of the single judge. The single ground (Ground 2) upon which leave was given concerns the direction given by the judge on causation. It is said that this direction did not accord with the guidance given by the Court of Appeal in the first appeal and was a misdirection.

4 The defendant also renews his application for leave to appeal on two grounds (Grounds 1 and 3) for which leave was refused by the single judge. In short, it is

said that, following the decision of the defendant to dispense with his legal team (leading and junior counsel and solicitors) towards the close of the prosecution case the judge should have granted a longer adjournment to the defence than she did, in particular to enable the defence to call a newly instructed expert. As part of that renewed application, the defendant seeks leave, pursuant to s.23 of the Criminal Appeal Act 1968, to adduce as fresh evidence, the evidence of a consultant forensic psychiatrist, Professor Jennifer Shaw.

5 We do not consider the renewed grounds to be arguable and would decline to admit the evidence of Professor Shaw. For the reasons that follow, we would refuse leave and dismiss this appeal.

The facts

6 The relevant factual background can be taken from part of the judgment of Sir Brian Leveson P, giving the judgment of the court in the first appeal (we also include as context, some of what was said about unlawful act manslaughter [2019] EWCA Crim 633):

> "3. The appellant and his two co-accused (both of whom were acquitted) ran a business which sold a chemical, Dinitrophenol ('DNP'), as a food supplement which was claimed to promote weight loss. On 4 April 2015, a 21-year-old student, Eloise Aimee Parry, purchased a quantity of DNP capsules from the appellant's business via the internet. On 12 April 2015, after taking eight of the capsules, tragically, she died.
> 4. We start with a description of DNP which is a chemical that was originally used in the manufacturing of dyes, wood preservatives, explosives, insecticides and other industrial products. It can act as a 'fat burning' and weight reducing drug by blocking the normal processes by which energy is stored in the body, causing energy to be released as heat. As a result, body temperature, metabolic rate, glycolysis and lipolysis (breakdown of glycogen and fat energy stores) all increase.
> 5. DNP has not undergone pharmaceutical development and has not been licensed as a medicinal drug. There has been no adequate research into its use as a pharmaceutical product and therefore no reliable evidence on which to base dosing recommendations. Ingestion by a human is to be regarded as hazardous and its toxic effects various and serious, including, inter alia, kidney failure, liver failure and cardiac arrest. There have been reported deaths in the United Kingdom resulting from the ingestion of DNP. Most of these have been in the context of acute overdose, although there have been cases of death apparently arising from regular use.
> 6. Prior to 2012, this type of poisoning was very rare. Thereafter, there has been an increase in the number of reported cases, suggestive of a rise in the use of DNP. Available statistics show, that of the 87 reported cases of DNP poisoning between 2007 and 2017, twelve resulted in death; there were six deaths in 2015 alone. Data collected by the National Poisons Information Service has caused Public Health England ('PHE') and the Food Standards Agency ('FSA') to publish warnings in respect of the dangers of using DNP as a weight reduction supplement. Efforts have been made by national and local agencies and authorities, including the FSA and police, to disrupt and restrict the sale of DNP. Much of the marketing of DNP is conducted via the

internet. As a result, educational work has been carried out targeting places where DNP might be sold or be considered attractive, such as gyms. The appellant was fully aware of the risks and the public concern relating to DNP; his denial that he was selling it for public consumption was rejected by the jury.

7. Turning to Eloise Parry, she was a young woman with a troubled past. She had been reported as suffering from depression and personality disorders and she had a history of self-harming, including overdosing on paracetamol tablets and taking cocaine. A consultant psychiatrist identified her as being very vulnerable and needing a high level of support. In 2011 she developed the eating disorder bulimia nervosa and received counselling. After completing her A level examinations she was detained in hospital under the Mental Health Act 1983 but subsequently embarked on a university degree. After gaining first class honours at the conclusion of her first year, she was again detained under the Mental Health Act, following another paracetamol overdose.

8. In February 2015, Ms Parry encountered DNP slimming pills on the appellant's website. There were numbers of contemporaneous accounts and records of what Ms Parry was doing and how she felt, both physically and emotionally. In e-mails and messages to university friends she described what she had taken and how she could not control her use of DNP. Despite appreciating that DNP was causing her harm, she continued to order further supplies from the appellant's business. She was repeatedly warned by her GP, social worker and friends of the danger from taking DNP, including the potentially fatal consequences.

9. On 10 April 2015 a friend of Ms Parry, Lydia Jane Rogers, warned her that she was going to die if she did not stop taking DNP to which Ms Parry replied: 'I wish I wouldn't too but the psychological desperation to take the pills is so hard to fight. They make everything feel okay. They give me control. Which I know is delusional but I feel it so overwhelmingly!'

10. The next day she went on an eating binge and, in the early hours of 12 April, took four DNP capsules (each of 250 mgm), followed a few hours later by a further four similar capsules, thereby exhausting her supply. She made a final purchase of two packets of DNP online. Shortly afterwards she became unwell and arrived at hospital, where her condition deteriorated. She suffered a cardiac arrest and died shortly before 3 pm.

11. The prosecution case was that the DNP acquired by Ms Parry and, in particular, the eight capsules containing DNP taken by her on the morning of her death had been sold to her by the appellant through his internet site; these were the substantial cause of her death. He had imported industrial 2.4 DNP from China in barrels and he put it into capsules at his home made up of 250 mgm (advertised at some stage as a daily dose for men) and 125 mgm (the dose for women): these dosages were published only after the death of Ms Parry. The income generated was approximately £100,000.

12. The appellant was fully aware of the dangers associated with DNP and was also aware that the sale of DNP was of interest to the authorities, who were trying to prevent or disrupt its sale. Active steps were taken by the appellant to disguise his activities, by using various internet identities, disguising the nature of the product in invoices and using arm's-length payment

services. There were large profits to be made as the raw 4 DNP, imported from China, was cheap but the capsules produced by the appellant were sold at a considerable mark up.

13. In short, the Crown alleged that the supply of these tablets for human consumption constituted an unlawful act which was dangerous and led to death (unlawful act manslaughter); it also constituted a gross breach of the duty of care owed to Ms Parry, crossing the criminal threshold, in circumstances which created an obvious and serious risk of death (gross negligence manslaughter).

14. While accepting that the appellant placed DNP on the market, it was denied that he did so with the intent or reasonable expectation alleged by the Crown. The defence contended that Ms Parry was an autonomous woman who decided to make a foolish decision in the exercise of her free will and killed herself, as she was entitled to do. The appellant's act of placing DNP on the market was too remote. Putting DNP on to the market did not cause her death and he bore no responsibility for Ms Parry ingesting it. It was not possible for him to have foreseen the possibility that she would take a handful of the capsules."

The first appeal

7 The Court of Appeal quashed the defendant's conviction for unlawful act manslaughter because it concluded, by analogy with the approach taken to the supply of heroin in *R. v Kennedy (No.2)* [2007] UKHL 38; [2008] 1 Cr. App. R. 19, that placing unsafe food on the market, of itself, was not a dangerous act; and that to place DNP on the market could not, therefore, amount to a dangerous act sufficient to amount to an unlawful act for the purposes of unlawful act manslaughter.

8 The Court of Appeal rejected the submission that the judge ought to have acceded to a submission of "no case to answer" in respect of gross negligence manslaughter. In that connection, the defendant had argued that there was insufficient evidence that DNP created an obvious and serious risk of death, the only risk being when there was an overdose; alternatively, because there was "a break in the chain of causation as a consequence of the voluntary (that is to say free, informed and deliberate) act of the deceased herself": see [68] and [70]. In rejecting that submission, the Court of Appeal said, at [69], that there was "clearly enough material to justify leaving the issue of serious and obvious risk of death to the jury".

9 The conviction of gross negligence manslaughter was quashed however because the Court of Appeal concluded that the direction given by the judge to the jury on the issue of causation was defective.

10 At [70] and following the Court of Appeal set out the parties' submissions on this issue:

"70. The alternative ground of appeal advanced by Ms Gerry [counsel then appearing for the defendant] (which was also relevant to unlawful act manslaughter) was based on her submission that there was a break in the chain of causation as a consequence of the voluntary (that is to say free, informed and deliberate) act of the deceased herself; the approach should be no different to the principle which operates to break the chain of causation as a consequence of the act of a third party. She argued that Eloise Parry did not lack autonomy

so that her ability to make up her own mind and ingest what, on any showing, were grossly excessive quantities of DNP constituted a novus actus interveniens which broke the chain of causation between the appellant's breach of duty and her death.

71. Ms Gerry argued that an adult woman albeit suffering from an emotionally unstable personality disorder and an eating disorder still retained autonomy to take risks and make mistakes, or even to commit suicide. She recognised that if unlawful conduct from a defendant has prompted the response of the victim, the defendant may remain liable if the reaction of the victim was within the range of responses which might be expected from a victim in his situation (see *Smith, Hogan & Ormerod's Criminal Law*, 15th edn at page 81 and the cases therein cited) but argued that her reaction was outside that range and not reasonably foreseeable."

11 The case for prosecution however, as identified at [72], was that:

"Ms Parry's free will was fettered and that she was coerced by the effect of her condition and the effect of the DNP such that her free will was sapped" and "her ability to exercise free and informed consent was compromised".

12 In the event, the Court of Appeal's analysis was this:

"74. In that part of the route to verdict dealing with autonomy the judge asked whether the prosecution had proved that Eloise Parry lacked capacity or was vulnerable and unable to exercise her free will when making the decision to take DNP. The reference to capacity came from the evidence of Dr Rogers applying the criteria set out in s. 3 of the Mental Capacity Act 2005. Thus, the question posed in the route to verdict in relation to gross negligence manslaughter did not reflect sufficiently clearly the issue that arose which was not merely whether it was *not* so unreasonable that it eclipsed the defendant's acts or omissions but which also depended on whether Eloise Parry's decision to take DNP may have been free, deliberate and informed decision, as Ms Gerry argued. Her capacity would be relevant to that issue.

75. In that regard, it is important to underline that capacity is not the same as autonomy. To direct the jury that provable lack of capacity as defined in the 2005 Act would be sufficient to demonstrate lack of autonomy was a misdirection particularly given the emphasis thereafter placed on the evidence of Dr Rogers. The second limb of the direction—the reference to Eloise Parry being 'vulnerable and unable to exercise her free will'—failed to assist the jury with what was meant in that context by the word vulnerable and how it interacted with any exercise of free will. Admittedly the judge was only using the term adopted in *Kennedy (No 2)*. But in that case the issue of capacity did not arise on the facts and there was no suggestion that the victim was suffering from a mental disorder that might deprive him of capacity. Further, the use of the word vulnerable was not discussed further. The direction should have required the jury to consider only the question of Eloise Parry's free, deliberate and informed decision.

76. Thus, the jury had to be directed, first, that the defendant must owe the victim an existing duty of care which, secondly, has negligently been breached in circumstances, thirdly, that were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required

criminal sanction. Fourth, the breach of that duty must be a substantial and operative cause of death, although not necessarily the sole cause of death. This last ingredient required further analysis which, without seeking to provide a definitive definition, could have been put to the jury in this way:

> In relation to the question of causation, the prosecution must make you sure that the victim did not make a fully free, voluntary and informed decision to risk death by taking the quantity of drug that she ingested. If she did make such a decision, or may have done so, her death flows from her decision and [the] defendant only set the scene for her to make that decision. In those circumstances, he is not guilty of gross negligence manslaughter.
>
> What does a fully informed and voluntary decision mean? Whether a decision is informed and voluntary will often be a question of degree. There is a range of factors to be taken into account. The starting point will be the capacity of the victim to assess the risk and understand the consequences. Does he or she suffer from a mental illness such as to affect their capacity? In that regard, you will consider the evidence of Dr Rogers, remembering always that it is for you the jury to attach such weight as you feel appropriate to that expert evidence. Against the background of what you have concluded about her capacity, you will consider her ability to assess the risk and understand the consequences relating to the toxicity of the substance and her appreciation of the risk to her health or even her life by taking as much as she did and whether it eclipsed the defendant's grossly negligent breach of the duty of care.

77. It is necessary to assess the direction which the judge gave against that suggested template. First, we do not consider that the question of capacity and vulnerability is of potentially less significance than in relation to gross negligence manslaughter as opposed to unlawful act manslaughter. Neither do we consider very helpful, in the context of this case, the formulation that the prosecution must prove that Eloise Parry's decision to take DNP in the quantity she did was not so unreasonable that it eclipsed the defendant's grossly negligent breach of the duty of care because the jury were given no assistance as to the way in which they could undertake that balancing exercise."

The re-trial

13 The defendant's re-trial commenced on 10 February 2020. The defendant was represented by experienced leading and junior counsel, Mr Lambert QC and Mr Ashley Hendron.

14 The prosecution relied, as it had done at the first trial, on the evidence of Dr Tim Rogers, a consultant psychiatrist with a specialism in eating disorders. His evidence was that Ms Parry lacked capacity when she ingested the tablets; specifically that her ability to understand and weigh information had been impaired by her significant mental health problems. Dr Rogers identified from Ms Parry's medical notes three separate mental health diagnoses: bulimia nervosa, emotionally unstable personality disorder and depressive episodes. In his expert opinion, the psychiatric conditions from which she suffered meant that she was less able to resist the compulsion to take DNP and that she did not have capacity.

15 The prosecution also relied upon the evidence of Ms Parry's GP, Dr Ingram. Dr Ingram had had a number of consultations with Ms Parry. Dr Ingram said Ms Parry had mental health difficulties, describing a depressive disorder, depression, paracetamol overdose, eating disorders, bulimia and self-harm. On 25 March 2015, following Ms Parry's collapse at university and admission to hospital, Dr Ingram and Ms Parry had discussed the dangers of DNP. Ms Parry had said that she felt unable to stop. After she had died, Dr Ingram noted that she felt Ms Parry was very well aware of the potentially life-threatening consequences of taking DNP but that she had such severe body dysmorphia that she was unable to stop herself from taking it.

16 Sally Cowman is a nutritional therapist, who had been treating Ms Parry since October 2014. She gave evidence that Ms Parry had disclosed that she was taking DNP for weight loss, that she knew it could have devastating results but that she had no control over taking it. Ms Cowman last saw Ms Parry on 9 April 2015 and was concerned for her welfare. Ms Cowman noted that Ms Parry was fragile and despondent; she had lost the capacity to think positively about her future; she knew that DNP could kill her but said that she was reliant on it and could not stop taking it.

17 Ruth Davies was Ms Parry's university tutor. She gave evidence that she had been aware of Ms Parry's past mental health issues and supported her at university. On the day that she died, Ms Parry sent her an email saying:

> "I've screwed up big time, binge/purged all night long. Took four pills at 4.00, another four when I woke up, started vomiting, now at hospital and I think I'm going to die. I'm so scared. I'm so sorry for being so stupid."

18 Professor Simon Thomas, a clinical toxicologist gave evidence that DNP was highly toxic and not safe for human consumption; and that information on "safe doses" of DNP was misleading as there was no safe dose, or proper information about the therapeutic values of DNP or the risks.

19 The defence case was that Ms Parry was an adult woman suffering from an emotionally unstable personality disorder and an eating disorder who made a fully free, voluntary and informed decision to take the DNP; she was not acting under any compulsion, nor was she vulnerable to feeling compelled. She was someone who wanted to take the DNP and so did. She was a bright and able university student who had conducted internet research and was well informed about the risks of DNP.

20 It was suggested also that DNP was widely used for dieting and bodybuilding, and that, whilst risks may have existed, they were not serious and obvious risks of death. The defendant's sale of the substance was simply meeting customer demand; he may have been negligent but not grossly so. Those who purchased DNP knew what they were buying; numerous people took DNP without any adverse effect.

21 Further, it was said that the jury could not be sure that the DNP ingested by Ms Parry was in fact supplied by the defendant. It was possible that she obtained the pills through a supplier at her university; she had sent a message indicating the university was investigating a man who was a supplier. There were also plenty of other DNP suppliers in the UK.

22 The defendant did not give evidence. His sole witness was Dr Richard Latham, a consultant psychiatrist. His evidence was given "back to back" with that of the prosecution experts. Dr Latham said that, in his opinion, there was insufficient

evidence to displace the presumption, under s.23 of the Mental Health Act 1983, that Ms Parry had capacity. In his opinion, Ms Parry's mental health issues influenced the way in which she made decisions, but she retained capacity. He explained that, where capacity is an issue, people can fluctuate from hour to hour. In the present case, Ms Parry was capable of understanding the information on DNP. When she took DNP for the last time, she was repeating something that she had done on previous occasions. However, Dr Latham also said:

> "The decision every time she took DNP; that was likely to be because of the cycle of behaviour associated with her mental disorder. She was bingeing, purging and using DNP. These were compensatory behaviours. I don't believe you could ever describe the situation of her taking DNP as fully free because this was part of her disorder and was driven by the symptoms of her disorder. Similarly with voluntariness, I do believe that her mental symptoms meant that her decision was not fully voluntary. The mental symptoms that she had; they do have an impact on her ability to resist the compulsion, so whilst I said before there is still likely to have been some degree of choice … that choice was very significantly impaired by her mental disorder."

23 This evidence was given on 26 February 2020. After it was given, the defendant apparently lost confidence in his legal team, counsel and solicitors and dispensed with their services. On 27 February 2020 (day 14 of the trial) solicitors newly instructed made an application to the judge on the defendant's behalf, to transfer the legal aid certificate to a new legal team.

24 On 28 February 2020, Mr Burton QC, now also newly instructed, made an application to discharge the jury or to be given at least a week to read into the case. The judge granted the application to transfer; she said as a matter of indulgence to the defendant because she did not wish him to represent himself but only on the basis that she would allow a short period for the new legal team to get up to speed, and that they would need to "soldier on": see *R. v Ulcay* [2007] EWCA Crim 2379; [2008] 1 Cr. App. R. 27. She therefore refused the application to discharge the jury or grant an adjournment of the length that Mr Burton had asked for. In her detailed written ruling dated 28 February 2020, the judge made it clear that she was only prepared to accede to the application to transfer "so long as the transfer can be achieved without derailing this trial" She added this:

> "So far as adjournment is concerned, I have equally made it clear that a change of legal representation at this stage is not a basis for discharging this jury and starting again, nor is it a reason for a long adjournment, which might end up having the same effect, or might serve to lose impetus in this trial. This trial will continue, within the timeframe originally envisaged."

25 The judge adjourned the case for a short period, until 3 March 2020, and directed the defence to notify her by 2 March if they intended to call further evidence. On 2 March 2020 Mr Burton sent an email to the judge in which he said that the defence now wished to apply either to discharge the jury or to adjourn the trial until 18 March 2020 in order to accommodate the holiday commitments of a newly instructed expert, Professor Jennifer Shaw, a clinical forensic psychiatrist. Professor Shaw had been approached and instructed during the short adjournment which the judge had granted, and had provided a short report dated 1 March 2020. In that report, she stated there was no evidence that Ms Parry lacked capacity and, in an

addendum sent by email on 2 March 2020, added that there was nothing about her mental disorder which suggested that her decisions were involuntary. On 3 March 2020, the defence made their application which the judge dismissed for reasons given in writing on 6 March 2020.

26 In short, the judge concluded that it was not in the interests of justice, or practicable, for there to be an adjournment; nor was it appropriate for the jury to be discharged. As to Professor Shaw's report, the judge said this:

> "11. I come then to Prof Shaw's evidence. Her report is dated 1 March 2020, last Sunday. She plainly had little time to consider the case. She says in terms that she has not reviewed [Ms Parry's] medical notes (para 4.3). I take it that she has not reviewed [Ms Parry's] diary or her many social media entries and emails either. Nor is she aware of the evidence of witnesses who saw [Ms Parry] in her final days and weeks who describe her state of mental health at that time. In the absence of a detailed analysis of the extensive documentation in this case, I could not accept any opinion offered, even on a preliminary basis, as sound.
>
> 12. Further, Prof Shaw's 'report' in truth simply recites the reports of Drs Rogers and Latham on the issue of capacity. She identifies capacity as the central issue (para 4.5) and comes down in agreement with Dr Latham in concluding that there was no evidence for lack of capacity (para 4.16). There are two points to make in response: (1) Dr Latham has already given evidence about [Ms Parry's] capacity and there is no need for the defendant to bring another expert to trial to say the same thing. (2) In any event, the issue of capacity has rather fallen by the wayside, given Dr Latham's concession on the wider issue of whether [Ms Parry's] decision was fully free, voluntary and informed (he accepted that it was not—which was to agree with the prosecution case—see my earlier ruling). Prof Shaw's main report does not deal with this wider question at all."

27 The judge added:

> "13. Prof Shaw does provide an addendum. It is 9 lines of text. The first 3 deal (again) with capacity. She then goes on to consider whether [Ms Parry's] decision to take DNP was 'fully free and voluntarily informed'. This is not quite the formulation that we have, in this trial, been working to (which is 'fully free, voluntary and informed'). I cannot therefore be sure that Prof Shaw is addressing the right issue. Then Prof Shaw refers to my summing-up, but does not indicate within that reference whether she understands the content of the agreed causation direction, as to what 'fully free' and 'fully voluntary' and 'fully informed' mean; again, I am not sure if she is addressing the right issue. She then returns to the issue of capacity, in the 7th line. Then, there is one last sentence, which really is the focus of Mr Burton's application, where she says: 'In terms of whether this was free and voluntary, there is nothing about her mental disorder which suggests that her decisions were involuntary'. I note that she does not address 'fully free' at all, and her views on 'voluntary' are not explained, or reasoned, at all. Perhaps it is a smaller point, but nor does she deal with 'fully informed'."

28 The judge went on:

> "15. But in any event, I am not persuaded that Prof Shaw really would be able to offer assistance to this court, even if I were to do what the defendant asks. I have already heard two expert psychiatrists of considerable standing in their respective fields give clear evidence that [Ms Parry's] substantial mental health problems interfered with her ability to make decisions; thus, that her decision to take DNP could not be described as 'fully free, voluntary and informed'. I do not find that view at all surprising. Indeed, to my lay ear, it sounds intuitively right. That means that the contrary view, which Mr Burton suggests Prof Shaw espouses, is the surprising one. I do consider it surprising to suggest that someone with such extensive mental health problems as [Ms Parry] had could still be acting in a way which was fully free, voluntary and informed. If my intuition is right, it means that there is a likelihood that once Prof Shaw was correctly directed on the law, had full sight of the documents including medical notes and witness evidence in this case, and had sufficient time to reflect on all this material, she would anyway align herself with the agreed view of Drs Rogers and Latham. That would mean that all this time and money had been wasted, and it would also mean that the defendant had been granted a new trial or a lengthy adjournment for no good reason."

29 The content of the written legal directions and route to verdict had been discussed (and agreed) between counsel for the prosecution and the defendant's then leading counsel, Mr Lambert QC, and the judge, on 21 February 2020. Following the judge's refusal to discharge the jury or adjourn the trial, the prosecution closed their case. There was then a further discussion about the legal directions before the judge. Mr Burton submitted that the previously agreed draft did not adequately reflect what Sir Brian Leveson P had to say in the Court of Appeal judgment [2019] EWCA Crim 633 at [75] and [76]. He highlighted how the proposed directions made no mention of "the eclipsing point", and that "to take 16 times what is the recommended dose" brought "the eclipsing point into play". In the course of exchanges with Mr Burton, the judge said that she did not consider the use of the word "eclipsing" to be "very helpful" for the jury. The trial then proceeded. The judge commenced her summing-up on 4 March 2020 and the jury were sent out on the morning of 6 March 2020.

30 The judge's written legal directions to the jury under the sub-heading "Fully free, voluntary and informed" contained in a section entitled "Causation of Death" said as follows:

> "21. In relation to the question of causation, the prosecution must make you sure that Eloise Parry did not make a fully free, voluntary and informed decision to risk death by taking the 8 tablets of DNP on the morning of 12 April 2015: this is the 'decision' you must think about. If this was a fully free, voluntary and informed decision, or may have been, that means that as a matter of law, her death was caused by her free choice, because in those circumstances, the defendant only set the scene for her to make that decision, but he did not cause her death.
>
> 22. What does a fully free, voluntary and informed decision mean? Lawyers sometimes refer to a person's ability to make a fully free, voluntary and informed decision as 'autonomy'. Whether a decision is fully free, voluntary and informed will be a matter of degree. It will be for you to judge whether

all the relevant factors in this case, including her eating disorder and her mental health generally, were such that you can be sure that her decision to take the DNP was not fully free, voluntary and informed, as the prosecution alleges.
23. It is important that you look at each element separately although there is likely to be some overlap between 'fully free' and 'voluntary'.
24. You will appreciate that a state of mind may fluctuate and just because some decisions Eloise Parry made at some times in her life may not seem to be fully free, voluntary and informed, it could still be the case that when she made the decision to take DNP on 12 April 2015, that decision was fully free, voluntary and informed. It is that decision you must think about.
25. When considering whether it was 'fully free' you will want to consider in particular the effect of any mental health condition. In ordinary language, you might talk about someone being vulnerable because of their mental health issues. This might include, as the prosecution say, that the person's ability to protect themselves from significant harm was impaired. The prosecution say that Eloise Parry was vulnerable because of her mental health problems and her psychological addiction to DNP, because those problems stifled her ability to make a fully free decision. The defence say that she was able to protect herself; they say that an adult woman suffering from an emotionally unstable personality disorder and an eating disorder can, and in this case did, make a fully free, voluntary and informed decision to take the DNP.
26. When considering whether the decision was 'fully voluntary' you will want to consider whether she was acting under any compulsion, whether caused by her mental health problems or any psychological addiction she may have had to DNP. Here too, you will consider whether she was vulnerable, which in this context would mean that her ability to resist feeling compelled to take the DNP was impaired. The prosecution say that there is clear evidence that she was acting under an element of compulsion because of her psychological dependence on DNP combined with her mental health problems. The Defence say she was not acting under compulsion, nor was she vulnerable to feeling compelled; she wanted to take the DNP and so she did.
27. When considering whether she was 'fully informed' you will want to consider whether she knew the risks that she was taking. The Prosecution say that she was not fully informed as the references she makes to 'safe' doses are nonsense and not supported by science. The defence say that she had conducted substantial research so knew full well what risks she was taking."

31 Having referred to the expert evidence on the capacity issue, under the heading "Summary" the directions continued:

"33. You should ask yourselves whether taking account of all the evidence in the case, Eloise Parry made a fully free, voluntary and informed decision to take the DNP? If you conclude that her decision was, or may have been, fully free, voluntary and informed, then that decision was the cause of her death, because as a matter of law, that decision supersedes or overtakes any grossly negligent act by the defendant in supplying the DNP in the first place. The defendant is not guilty of manslaughter.
34. If, on the other hand, you are sure that Eloise Parry did not make a fully free or fully voluntary or fully informed decision to take the DNP, then, if the

> defendant was in gross breach of his duty of care owed to her, his negligence remains a substantial and operative cause of her death, even if it was not the sole cause of her death. He is guilty of manslaughter."

The ground of appeal

32 Mr Burton submits that the judge misdirected the jury on the issue of causation. Specifically, he submits that the judge failed to follow the guidance given in the first appeal judgment at [76] because she failed to direct the jury that that even if they concluded Ms Parry's decision was not fully free and voluntary, they still had to assess whether the decision to take the amount of DNP that she did was such that it could be said "to eclipse" the defendant's gross negligence. He submits that, on a proper analysis of the guidance given by Court of Appeal, this further step was required in order to establish the necessary link between the defendant's supply of DNP and Ms Parry's death, and that Ms Parry's action in taking the amount of drugs that she did, did not break the chain of causation,

33 In our judgment, this submission is misconceived. First, it must be borne in mind that what was said by the Court of Appeal, as the court itself made plain, was suggestive only of the sort of direction that might be given; it was not intended to be prescriptive. Secondly, we do not think that the passage on which Mr Burton particularly relies is authority for the proposition that before the jury could safely convict, the prosecution were and would be required to surmount the further hurdle or take the further step which he identifies.

34 The submission now made relies on an interpretation of the suggested direction which ignores its full content. The direction consisted of two paragraphs. Mr Burton cites only the second paragraph. That paragraph's purpose is to explain the first paragraph which dealt with the requirement that the breach of duty had to be a substantial and operative cause of death. The breach of duty would not be a cause of death if Ms Parry had or might have made a fully free, voluntary and informed decision. That is what is set out in the first paragraph of the direction. The second paragraph expands on the term "fully free, voluntary and informed". The final sentence does not add an extra element to the requirement.

35 Thus, as is clear from what the Court of Appeal did say, the key issue was whether Ms Parry had or might have made a fully free, voluntary and informed decision to take DNP; if that was the case, the jury could not be sure that the defendant's breach of duty was a cause of her death. We repeat the following passage from the Court of Appeal's judgment [2019] EWCA Crim 633:

> "In relation to the question of causation, the prosecution must make you sure that the victim did not make a fully free, voluntary and informed decision to risk death by taking the quantity of drug that she ingested. If she did make such a decision, or may have done so, her death flows from her decision and [the] defendant only set the scene for her to make that decision. In those circumstances, he is not guilty of gross negligence manslaughter."

36 What followed was an explanation of what is meant by "fully free, voluntary and informed" ("What does a fully informed and voluntary decision mean?"). It is in that context, that the "starting point" taken is "the capacity of the victim to assess the risk and understand the consequences"; and then of her "ability to assess the risk and understand the consequences relating to the toxicity of the substance

and her appreciation of the risk to her health or even grossly negligent breach of the duty of care". As Sir Brian Leveson P said at [77], what is required is a "balancing exercise" in order to decide whether the prosecution has established that a defendant's breach of duty is a substantial and operative cause of death, even if it is not the sole such cause, bearing in mind, of course, that the jury would only be considering the causation issue at all if they have already concluded that the defendant's conduct amounted to gross negligence and required criminal sanction.

37 The judge gave a much fuller direction than the one set out by Sir Brian Leveson P. That is not surprising because she had to relate the legal direction to the evidence called in the trial. As can be seen she explained that it was for the prosecution to make the jury sure that Ms Parry "did not make a fully free, voluntary and informed decision to risk death" by taking the DNP which she did, spelling out to the jury that if her decision "was a fully free, voluntary and informed decision, or may have been, that means that, as a matter of law, her death was caused by her free choice, because in those circumstances, the defendant only set the scene for her to make that decision, but he did not cause her death". The judge went on to address the matters raised in the second part of the suggested direction with commendable clarity. Capacity was, of course, addressed in some depth. So too was the amount of DNP which Ms Parry took. The judge pointed out that whilst the prosecution's case was that there is no such thing as a safe dose, it was the defence case that Ms Parry "had conducted substantial research so knew full well what risks she was taking".

38 We note that before she came on to deal with the evidence concerning the causation issue, the judge reminded the jury that it was the defence case not only that the defendant's breach of duty was not truly exceptionally bad, but also that:

> "What is said is that there are lots of people who want this product, DNP, for whatever reason; lots of people who take it and who have no adverse effect. And in this case what happened was Eloise Parry took a massive overdose, but that was her decision and we will come on to that, but that is why she died."

There can be no doubt, in these circumstances, that the jury would have had in mind that it was for them to consider the significance of the fact that Ms Parry took as much DNP as she did, as part of the balancing exercise which their assessment of the issue of causation required.

39 Finally, insofar as the complaint centres on the absence of the word "eclipsed" from the judge's written directions, it is to be noted that, no doubt out of an abundance of caution, the transcript shows that the judge did add the words: "or eclipses" after "supersedes or overtakes" when taking the jury through her written directions in the course of her summing-up. What matters, however, is the substance and correctness of the legal directions, rather than the use of this particular verb. The content of those directions had been agreed as we have said with the defendant's previous counsel; and in our view, there was nothing wrong with them. Specifically, the jury were accurately directed on the issue of causation and their approach to the core issue of "free, voluntary and informed consent". It follows that the appeal against conviction must be dismissed.

The renewed applications for leave to appeal

40 We turn next to the grounds for which leave was refused.

41 The first of these grounds is that the judge's refusal on 28 February 2020 (a Friday) to discharge the jury or to adjourn the trial for at least a week (rather than until the following Tuesday, 3 March 2020) gave the defendant's newly instructed legal team too little time in which to read into the case.

42 Like the single judge, we see no merit in this proposed ground. The only reason a new legal team became involved was because the defendant chose to sack his solicitors and counsel. As already indicated, this was because he had apparently lost confidence in them when Dr Latham gave evidence that was damaging to his case. This was not a legitimate basis for a loss of confidence, even assuming for this purpose that this is ever a proper ground for a change of representation.

43 No significance can be attached to the fact, as it is said to be, that the case raised a number of complex issues or to the number of exhibits, amounting to some 11,500 pages, or to the fact that the jury bundle consisted of almost 1,600 pages. First, as Mr Barraclough QC for the Crown points out, the evidence in the jury bundle had been reduced to schedules and the points for the jury to consider fell within a relatively narrow compass. Secondly, Mr Burton was unable to demonstrate, even arguably, that the limited time available to the new legal team materially affected the presentation of the defendant's case.

44 The only example given was that, due to lack of time, counsel failed to notice the significance of evidence concerning the way in which the defendant supplied DNP in 2014. This, however, amounts to nothing. The evidence was in the jury bundle. If it was of real significance, it was there for the jury to take into account. In fact, it was not of any significance. In 2014 the defendant referred on social media to his DNP being supplied in red and white capsules. There was evidence that the DNP capsules in Ms Parry's possession in 2015 were yellow. The fact that the defendant used red and white capsules in 2014 was of marginal value in determining the colour of DNP capsules which he supplied in 2015.

45 We would add two points. First, the associated complaint that the judge declined to refer to this aspect of the case is unsustainable. As the judge noted in some of the exchanges with Mr Burton during breaks in her summing-up, the defendant had chosen not to say whether the DNP capsules which Ms Parry had in 2015 were supplied by him; and in our view, she was entitled to decline to mention the evidence of what the defendant had said on social media given that he had chosen not to give evidence before the jury. Secondly, the evidence before the jury (including from Ms Parry's electronic devices and bank statements and the like) that it was DNP admittedly supplied by the defendant to Ms Parry that caused her death, was compelling.

46 The second ground now advanced (the ground described as Ground 3(a)) is that the judge ought to have discharged the jury or adjourned the trial on 3 March 2020 to enable Professor Shaw's report "to be finalised" and to permit her to give evidence on the defendant's behalf.

47 We see no merit in this ground either.

48 The starting point is that the evidence it was proposed that Professor Shaw should give covered the same ground as that of the expert witnesses who had already given evidence at the trial. In those circumstances, what was said in *R. v Kai-Whitewind* [2005] EWCA Crim 1092; [2005] 2 Cr. App. R. 31 at [97] is apposite:

> "… The fact that the expert chosen to give evidence by the defence did not give his evidence as well as it was hoped that he would, or that parts of his evidence were exposed as untenable (as, certainly on one view, occurred with Dr Rushton) thereby undermining confidence in his evidence as a whole, does not begin to justify the calling of further evidence, whether to provide 'substantial enhancement' of the unsatisfactory earlier evidence, or otherwise. Where expert evidence has been given and apparently rejected by the jury, it could only be in the rarest of circumstances that the court would permit a repetition, or near repetition of evidence of the same effect by some other expert to provide the basis for a successful appeal. If it were otherwise the trial process would represent no more, or not very much more, than what we shall colloquially describe as a 'dry run' for one or more of the experts on the basis that, if the evidence failed to attract the jury at trial, an application could be made for the issue to be revisited in this court. That is not the purpose of the court's jurisdiction to receive evidence on appeal."

49 The judge was not merely entitled to refuse the application, in our view, she was right to do so for the reasons she gave. It is to be observed that Professor Shaw's short report did not address the question whether Ms Parry's decision to take DNP was fully free, voluntary and informed; and Professor Shaw's subsequent attempt to fill this gap in an addendum email (after prompting from the defendant's solicitors) did not, as the judge identified, address the correct test that the jury had to apply.

50 What little evidence there was from Professor Shaw related primarily to the question of capacity. Nothing she had to say added materially to the evidence given. The fact that Dr Latham may have given evidence contrary to the defendant's case was neither here nor there. This could provide no justification for permitting the course proposed on the defendant's half, namely to permit a second lately instructed expert to give evidence covering the same ground as Dr Latham and/or to contradict what he had said, and to delay or derail the trial in consequence.

51 Nor do we see any merit in the third ground, namely that described as Ground 3(b). This is that the evidence which Professor Shaw put in a report dated 14 April 2020, prepared after the trial, would have been admissible, and renders the jury's verdict unsafe.

52 The grounds of appeal do no more than cite the overall conclusion of Professor Shaw and argue that the jury were deprived of knowing that there was expert disagreement in relation to the findings of Dr Rogers. For us to receive the evidence of Professor Shaw, we would have to conclude that it may afford a ground for allowing the appeal. The mere fact of expert disagreement cannot lead to that conclusion. It is necessary to demonstrate that the substance of that disagreement, had it been before the jury, might have affected the verdict. Nothing in Professor Shaw's report supports such a conclusion

53 We would add in this respect that paras 6.18–6.20 of the 14 April 2020 report deal with the question of whether Ms Parry's decision was fully free, voluntary and informed. In relation to "fully free", Professor Shaw sets out all of the features indicating that the decision was not fully free. Her conclusion that the decision, in fact, was fully free depended on an assertion of fact which it was for the jury to determine. In respect of "fully voluntary", Professor Shaw's conclusion was as follows

> "… whilst [Ms Parry's] urge to take the drug at times overcame her decision not to take the drug, this decision was in my view still under her control".

On the face of it, that conclusion was internally contradictory.

Conclusion

54 It follows that we refuse the renewed applications for leave to appeal, together with the associated application to adduce fresh evidence under s.23(2) of the Criminal Appeal Act 1968; and that this appeal must be dismissed.

Appeal against conviction dismissed.

Health and Safety Committee Meeting

Date: 17th January 2023

Health & Safety Team

- New contract negotiated and signed
  - Unfortunately Peoplesafe have reneged on the contract
  - Ongoing discussions with them via procurement

Filled positions

- Two Fire Safety Advisors
- Trainer
- Assistant Health and Safety Advisor Manual Handling

Vacant positions

- Health & Safety Advisor
- Head of Fire Safety Management
- Interim Senior Fire Safety Advisor

UHB Classroom Training Compliance 7.2

Date	Moving and Handling level 1b object handling classroom	Moving and Handling level 2 patient handling	Violence and Aggression Module C Classroom	Violence and Aggression Module D Classroom
09-10-2021	16.57%	24.02%	16.67%	22.35%
30-09-2022	46.03%	34.12%	24.02%	30.41%
06-01-2023	48.77%	33.85%	25.64%	41.73%
3 month Difference	2.74	-0.27	1.62	11.32

H&S Culture Plan Update

- Theme 1 – Training
- Theme 2 – Risk & Incident Management
- Theme 3 – Communication
- Theme 4 – Measuring Performance
- Theme 5 – Audit & Review
- Theme 6 – Fire

October 2022

Tracker sets							
Title	Total Group	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Count of Not Started	70	16	17	5	6	3	23
Count of In Progress	34	6	4	7	7	4	6
Count of Complete	8	8	0	0	0	0	0

January 2023

Tracker sets							
Title	Total Group	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Count of Not Started	56	16	8	5	3	1	23
Count of In Progress	42	6	12	4	8	6	6
Count of Complete	14	8	1	3	2	0	0

- 01/12/2022 Datix Ref:19602
- Waste yard operative sustained head and shoulder injuries from a 770 litre bin that fell from a Stericycle lorry whilst being offloaded
- Operative fell to his knees then collapsed unconscious
- Reported under RIDDOR
- Improvements made to delivery lorries and procedures
- CAVUHB have implemented an exclusion zone around delivery activities
- Staff member now back in work


SRCL
Mohamed.Safrah
18/01/2023 09:35:12


Stericycle
SRCL

UHB RACI

7.2

END

Fire Safety Update

7.3

Fire Safety Staff Update 7.3

- Struggled to attract a pool of credible candidates for Senior Fire Safety Advisor position
- Re-evaluated position will now become Head of Fire Safety Management at a band higher. Role will assume some responsibilities for fire that currently sit with Head of H&S
- Sent out an expression of interest for a 3 month secondment for a senior fire safety advisor. This is an interim post.
- 2 new Fire Safety Advisors in post
- A Fire Safety Advisor has retired after his part time three month contract ended in January
- Secured the services of a previously retired Senior Fire Safety Advisor from CAVUHB 2 days a week for 3 months

Fire Risk Assessment 7.3

- The UHB are currently 98.7% compliant with the ongoing risk assessment programme.

- There are currently 53 high-risk actions scoring 16+, this has reduced by 16% over the previous period. This is a new metric being brought to committee and it will be incorporated into the monthly H&S dashboard going forward which will bring it under more scrutiny.

- The Health and Safety team is currently looking at improved ways of tracking the completion of these actions by stake holders around the health board.

Unwanted Fire Signals 7.3

- Total UWFS YTD – 308
- YTD Attended by SWFRS – 246

Average of 34 per month which is an increase on the previous 3 months of 32.6

- Some of these events are avoidable and attributed to staff behaviours

END

T2 Animal Laboratories

- Request from HSE to take a voluntary statement from the Head of Estates and Facilities in a meeting on 5th January 2023
- Not deemed appropriate during the meeting as inspector was still gathering information
- Request to be afforded time to respond to questions agreed
- Head of H&S signed a voluntary statement for information previously sent in February 2022
- Next meeting planned for 01/02/2023

UHW Theatre Trolleys

- Requested update on UHW Theatre Trolleys request - Last correspondence 23/03/2022.
- Issue was verbally closed out during T2 meeting. Awaiting written confirmation

Enforcement notice EN59/21 against A4

- Article 8 Duty to take general fire precautions
  - Physical controls and training
  - Compliance date extension agreed to 31st March 2023
- Remedial work almost complete, currently awaiting delivery of a fire door set. Once installed SWFRS will be invited in to inspect all the outstanding work and necessary documentation

Fire Enforcement 7.4

- Fire Audit meeting held with fire safety team and SWFRS
- SWFRS see greater benefit in auditing areas that have been refurbished
- Plan to start with A4 as per EN59/21
- Noah's Ark Children's Hospital for Wales is next on the schedule
- They will take guidance from us thereafter in line with our major projects
- Previous agreement with them reaffirmed over issuing enforcement notices for common risks where other mitigation exists i.e. Fire dampers at UHW

END

King V's CAVUHB

9.2

- Indictment - Four Statements of Offences in relation to EN3/21
- Not Guilty plea entered for all four counts
- Trial date set for 9th October 2023
- Two weeks have been set aside for trial
- Next step is for the prosecution to provide full disclosure by 24th February
  - Schedule of unused material

Report Title:	Fire Safety Compliance Report				Agenda Item no.	7.3	
Meeting:	Health & Safety Committee		Public Private	✓	Meeting Date:	17/01/2023	
Status *(please tick one only):*	Assurance	✓	Approval		Information		
Lead Executive:	Executive Director of People and Culture						
Report Author (Title):	Head of H&S						

Main Report
Background and current situation:

The UHB has a statutory responsibility to protect all persons that could be affected by its operations from the risk of injury or death due to fire. The enforcing authority of current fire safety legislation for Cardiff and the Vale is South Wales Fire and Rescue Authority (SWFRA) and they are lawfully empowered to monitor and enforce compliance of all fire safety matters under the Regulatory Reform (Fire Safety) Order 2005.

South Wales Fire and Rescue Service (SWFRS) agree a program of visits with the University Health Board's (UHB's) Senior Fire Safety Officer (SFSO) to enable them to undertake fire safety audits PAN Estate. Audits may result in written notices being served on the responsible person for Cardiff and Vale University Health Board (C&V UHB) by the enforcing authority where they deem that C&V UHB has failed to comply with current fire safety legislation i.e. the Regulatory Reform (Fire Safety) Order 2005.

Written notices can be:

- FSA04 - An official notice that confirms the standard of fire safety at the time of audit appears to comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005, therefore no further action is required by the Local Fire and Rescue Authority at that time.
- IN02 – An alternative informal notice issued for advisory fire safety deficiencies - not time bound
- IN01- A time bound Informal Notice issued for fire safety contraventions and/or deficiencies that are deemed not to warrant enforcement action
- Enforcement Notice - Identifies serious fire safety contraventions and/or deficiencies
- Prohibition Notice - This notice prohibits the use of an area or premises and is effective immediately

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

This paper provides an update on four key fire safety compliance and management obligations:

1. **Significant Incidents**
2. **Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations**
3. **Fire Risk Assessment**
4. **Fire Safety Training**

(See Appendix 1 Supporting Documentation)

Recommendation:

The Health and Safety Committee is requested to:

- Consider on-going efforts to meet the requirements of enforcement action and C&V UHB's statutory and mandatory fire safety obligations.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	✓	Long term	✓	Integration		Collaboration		Involvement	✓

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
Risk of further enforcement action if current standards are not improved and/or maintained
Safety: Yes/~~No~~
Safety of staff will be compromised if training figures are not improved and maintained
Financial: Yes/~~No~~
Potential negative financial implications of not maintaining statutory and mandatory fire obligations.
Workforce: Yes/~~No~~
Potential negative safety work force implications of not maintaining statutory and mandatory fire obligations
Legal: Yes/~~No~~
Potential reputational damage is a real possibility if fire safety statutory and mandatory obligations are not met by C&V UHB
Reputational: Yes/~~No~~
Potential reputational damage is a real possibility if fire safety statutory and mandatory obligations are not met by C&V UHB
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: Yes/~~No~~

Appointed architects and designers for all new major capital projects must consider this matter. In order to reduce our carbon footprint and comply with this regulation they are already proposing to move away from using traditional fire-resisting/non-combustible structural elements such as steel, brick and concrete to using combustible structural elements such as timber and laminates. The use of these construction materials will have a direct impact on the standard of fire resistance of building and consequently impact on the safety of all building occupants therefore the installation of life safety and property protection suppression systems will become an essential element of all new buildings.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Health and Safety Committee	23/01/2023

APPENDIX 1

Supporting Documentation

1.0 Significant Incidents

Table 1

Fire incidents, **reported and recorded**, between 01/10/2022 and 29/12/2022

There have been two fire incidents recorded during this reporting period.

Fire Incidents 01/10/2022 to 29/12/2022	Fire Incidents
Hafan Y Coed, Llandough Hospital, Penlan Road, LLANDOUGH	1
University Hospital of Wales, Heath Park, CARDIFF	1

Hafan Y Coed 20-10-2022
A fire incident occurred at Hafan Y Coed on the 20th October 2022, at approximately 07:45 in a single bedroom. The fire was the result of malicious ignition set by a known patient. The patient informed staff they had set fire to their clothing. The patient did not sustain any injury and no staff or other patients were affected. Fire detection did not activate due to the small amount of smoke and the fire had self-extinguished by the time the patient had reported it. SWFRS did not attend.

UHW 02-12-2022
University Hospital Wales, Ward A1 South experienced a fire incident on the 2nd of December 2022 at approximately 01:20 in the corridor exterior to the ward toilet. Staff witnessed a small flame at the toilet door, clinical staff attended and witnessed a patient had used a lighter to ignite signage on the outside of the toilet door. This was extinguished by nursing staff on the ward using a fire blanket and no alarm was raised. SWFRS did not attend. Security were informed who attended the ward and confiscated the lighter from the patient. Site managers spoke with the patient regarding the risks of this behavior. This incident was reported to police via 101. The head of health and safety has reported this incident to the Healthcare Fire Team with SWFRS and the importance of following correct UHB protocol reaffirmed with ward staff.

2.0 UHB Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations (FFAA's)

False alarms and unwanted fire signals lead to disruption of service/patient care, increased costs and unnecessary risk to those required to respond to the alarm.

This reporting period saw 104 UWFS in total across the UHB estate, this is a 6% decrease over the previous 3 month period. 22 activations were not attended by the fire service due to the speed of attendance and reaction by fire response personnel and other colleagues (See Table 2 and 3 below).
In response to this the fire team are in the process of reviewing several key documents which will firm up the fire strategy and response to a fire signal, the output will be fed into local emergency plans.
The documents are in scope for the 3 year Health and Safety Culture Plan however, they have been brought forward on the timescale.

- Fire Safety Policy Statement of Intent
- Fire Safety Policy
- Fire Safety Management Arrangements
- Fire Strategy Template for Community Sites
- Control of Ignition Sources in HYC

Table 2

Unwanted Fire Signals (UwFS's) **attended by the fire service** between 01/10/2022 and 29/12/2022

Hospital	UwFS only	Actuation devices	Grade
Barry Hospital	**0**	**562**	**++**
Cardiff Royal Infirmary	**4**	**2000**	**Performance level 1**
Hafan Y Coed	**3**	**1274**	**Performance level 1**
Llandough Hospital	**13**	**6500**	**Performance level 1**
Rookwood Hospital	**3**	**425**	**Performance level 1**
St David's Hospital (Cardiff)	**0**	**600**	**++**
University Hospital of Wales	**59**	**20000**	**Performance level 3**
Whitchurch Hospital	**0**	**2059**	**++**
Total	**82**	**33420**	

++ Locations with zero UwFS do not have a performance listed.

Table 3

False Fire Alarm Activations (FFAA's) **not attended by the fire service** between 01/10/2022 and 29/12/2022

Hospital	False alarms	Actuation devices	Grade
Barry Hospital	0	562	no incidents
Cardiff Royal Infirmary	1	2000	A - performance should be maintained
Hafan Y Coed	4	1274	A - performance should be maintained
Llandough Hospital	2	6500	A - performance should be maintained
Rookwood Hospital	1	425	A - performance should be maintained
St David's Hospital (Cardiff)	0	600	no incidents
University Hospital of Wales	14	20000	A - performance should be maintained
Whitchurch Hospital	0	2059	no incidents
Total	22	33420	

Table 4

Unwanted Fire Signals (UwFS's) and False Fire Alarm Activations (FFAA's)
YTD (01/04/2022 to 29/12/2022)
The table shows there have been 308 activations year to date. This has put us on an average of 34 per month which is an increase on the previous 3 months of 32.6.

Whilst this figure reflects the size and age of our fire alarm detection system and the complexity of our largest sites, as detailed above, the approach adopted by the UHB in relation to UWFS is being reviewed by the fire team.

Hospital	False alarms including UwFS	Actuation devices	Grade
Barry Hospital	1	562	A - performance should be maintained
Cardiff Royal Infirmary	7	2000	A - performance should be maintained
Hafan Y Coed	24	1274	B - 10% reduction in UwFS
Llandough Hospital	61	6500	A - performance should be maintained
Rookwood Hospital	9	425	C - 25% reduction in UwFS
St David's Hospital (Cardiff)	0	600	no incidents
University Hospital of Wales	205	20000	A - performance should be maintained
Whitchurch Hospital	1	2059	A - performance should be maintained
Total	308	32420	
Total UwFS's Attended by SWFRS	246		
Not attended by FRS	62		

3.0 Fire Risk Assessment

The principle fire safety legislation applicable to all UHB premises is the Regulatory Reform (Fire Safety) Order 2005 (FSO) enforced by the Local Fire Authority. To be compliant with this legislation a fire risk assessment must be completed for every building or ward or department. Currently there are 425 risk assessment reports that are being regularly assessed and reviewed by members of the fire safety team either annually, bi or tri-annually or if there is a significant change to the assessable area.

The UHB are currently 98.7% compliant with the ongoing risk assessment programme. Of the 6 overdue, the longest is 27 days

There are currently 53 high-risk actions scoring 16+, this has reduced by 16% over the previous period. This is a new metric being brought to committee and it will be incorporated into the monthly H&S dashboard going forward which will bring it under more scrutiny.
The Health and Safety team is currently looking at ways of tracking the actioning and closing of these actions by stake holders around the health board.

4.0 Fire Safety Training

Table 5

Org L4	Fire Safety Compliance April - Start of financial Year	Fire Safety Compliance October - Start of reporting quarter	Fire Safety Compliance December - current	Compliance change from financial year start.
001 All Wales Genomics Service	83.39%	73.36%	83.44%	0.05%
001 Capital, Estates & Facilities	70.49%	65.37%	74.98%	4.49%
001 Central & Reserves	100.00%	88.89%	90.00%	-10.00%
001 Children & Women Clinical Board	66.73%	59.11%	67.20%	0.47%
001 Clinical Diagnostics & Therapeutics Clinical Board	73.97%	58.91%	74.05%	0.08%
001 Corporate Executives	64.14%	61.44%	72.24%	7.90%
001 Medicine Clinical Board	53.13%	52.48%	61.22%	8.09%
001 Mental Health Clinical Board	65.96%	55.90%	60.56%	-5.40%
001 Primary, Community Intermediate Care Clinical Board	70.36%	70.67%	73.79%	3.43%
001 Specialist Services Clinical Board	61.21%	58.07%	62.79%	1.58%
001 Surge Hospitals	40.00%	42.86%	100.00%	60.00%
001 Surgical Services Clinical Board	58.46%	57.64%	59.85%	1.39%
001 Trust *	66.67%	not in existence on this date	0.00%	-66.67%
001 UHB Healthboard Total	65.04%	59.3%	67.06%	2.02%

* 001 Trust clinical board group is used during recruitment, special situations, and specialised temporary, or adjusted staff. It contains an extremely small percentage of overall staff, sometimes zero.

The compliance figures outlined in Table 4 relates to the start of the financial year, commencement of the quarterly reporting period and end of the reporting quarter. The percentage change is from the start of the year to end of reporting period.

The large positive increases are largely attributable to the drop in sessions conducted through Fire Safety Week which ran from 17th to 21st October. During this week 1859 colleagues were trained.

Report Title:	Enforcement Agencies				Agenda Item no.	7.4	
Meeting:	H&S Committee		Public	x	Meeting Date:	17/01/2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Director of People and Culture						
Report Author (Title):	Head of Health and Safety						

Main Report
Background and current situation:

Background and Current Situation:

As appropriate the Health and Safety Committee and Health and Safety Operational Group is briefed about action taken in response to correspondence from the HSE, SWFRS and other enforcement agencies that fall within the remit of the H&S Department.

Health and Safety Executive (HSE)
No new concerns raised.

T2 UHW Animal House Ventilation
Request for information from the HSE regarding maintenance and agreements between CAVUHB and Cardiff University in relation to the different types of local exhaust and extract ventilation systems associated with T2 animal house. Information forwarded to the HSE on February 11th 2022. HSE inspector requested a visit to obtain a voluntary statement from the Head of Estates and Facilities. At the time of writing this meeting was to be held on 5th January 2023.

UHW Theatre Trolleys
The Health Board received a short notice request (3 Days) from the HSE to visit theatres at UHW to review the manual handling systems employed by this work group. Concerns of non-essential visits from the Director of Nursing for the Surgery Clinical Board was relayed back to the HSE and as a result the visit has been postponed however, information and documents have been forwarded to the HSE Inspector for review (22nd March 2022). Currently awaiting a reply.

South Wales Fire and Rescue Service (SWFRS)

During the period there were no new enforcement notices issued whilst two remain open.

21st April 2021: EN03/21 issued against Hafan Y Coed in relation to failing to adequately control ignition sources. This is ongoing and has been raised to the South Wales Fire and Rescue Service (SWFRS) compliance team. SWFRS have now issued a letter under caution, a response to which was sent on 21st January 2022.
A meeting has been arranged for 18th October with SWFRS to discuss this.

SWFRS are prosecuting CAVUHB in relation to the above enforcement notice. A magistrates hearing took place on 13th December 2022 where the Health Board entered 'No Plea'. At the time of writing the next hearing is to be at Cardiff Crown Court on 10th December 2023.

8th October 2021: EN59/21 issued against ward A4 at UHW in relation to physical fire controls such as fire dampers and fire and smoke resisting doors and also staff training requirements. The

compliance date for the outstanding actions from this notice has been extended from 6th April 2022 to 31st March 2023

The necessary improvements to satisfy the terms of the enforcement notice is now largely complete apart from some small remedial issues. Current plan is to invite SWFRS back at the end of January, beginning of February 2023.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The UHB have reassured SWFRS that all reasonably practicable steps have and are being taken in resolving the identified non-conformances. Assurance is provided by the current mitigation in place on A4. CAVUHB are working closely with SWFRS on all other issues.

Recommendation:

The Health and Safety Committee is asked to:

a) Note the content of the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

No

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

No

Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
H&S Committee	23/01/2023

Mohamed,Sarah
18/01/2023 09:35:12

Report Title:	Waste Management Compliance Report				Agenda Item no.	7.5	
Meeting:	H&S Committee		Public	x	Meeting Date:	17/01/2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Finance						
Report Author (Title):	Waste & Compliance Manager						

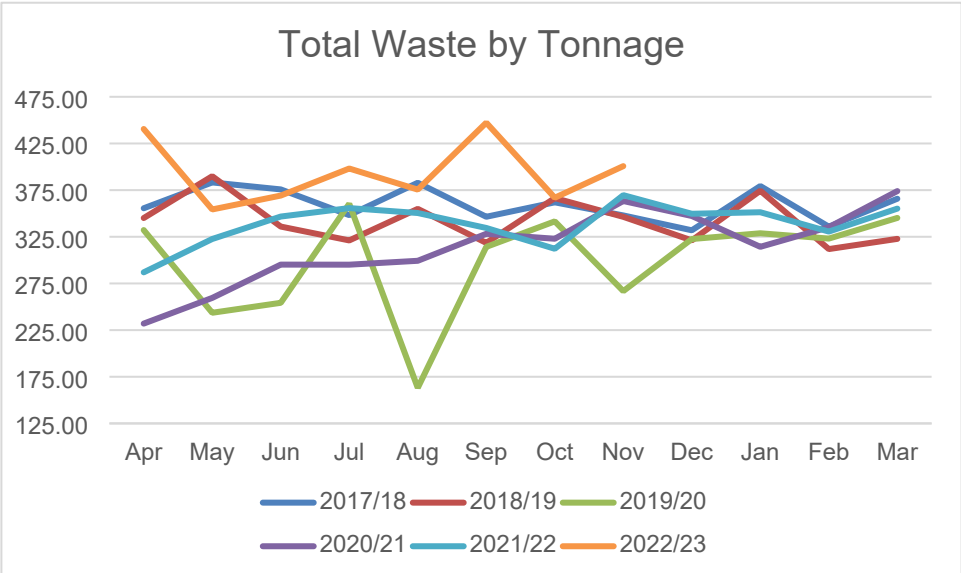
Main Report
Background and current situation:

The purpose of this paper is to provide assurance to the Health & Safety Committee, that waste services managed by the Capital, Estates and Facilities Service Board are operated in line with the relevant legislative and mandatory standards applicable in Wales.

The current University Health Board Wide Waste Department continues to process higher volumes of waste than would normally be expected, with the continuing disposal of additional Personal Protective Equipment (PPE) and the impact of The Healthcare Environment Standards (HES).

The move to de-clutter areas to ensure wards and clinical areas can be cleaned more effectively to comply with the HES is resulting in a significant increase in larger items of equipment for disposal. Chairs, tables, office furniture and racking, no longer required or damaged and considered an Infection Control risk are being scrapped, adding to the overall waste increase.

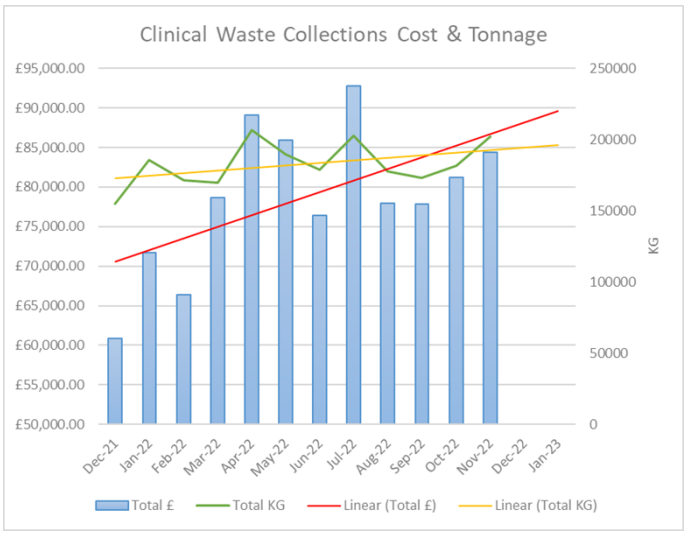
The graphs below indicate the overall amount and cost of waste over the last 6 years. It is noticeable that whilst the tonnage in general had some degree of movement, the costs over this financial year have increased significantly. There are number of factors that impact on this, the type of waste where clinical waste is more costly, to dispose of than general waste, increase in suppliers' costs for fuel and energy etc.



Clinical Waste:

Clinical Waste volumes remain high at 182 tonne per month (on average, Dec 21 - Nov 22), compared to 166 tonne per month (on average, Dec 20 – Dec 21), the costs of treatment and disposal at nearly £80k/month, compared to the previous year of £54k/month.

Fuel surcharges were implemented from July increasing costs, however these seem to have fallen in line with falling fuel costs.



An audit of the High Temperature (HT) Disposal Waste (orange bags) was undertaken by the contractor in October 2022, where bags from a number of wards at UHW were examined. Major non-conformities were identified, where pharmaceutical, food and liquid waste had been mixed with clinical waste. The amounts identified were above the acceptable tolerance levels.

Consequently, the contractor has advised that, for a period of 3 months commencing 19th December 2022, all orange bags will be incinerated to ensure all waste contaminated or otherwise does not pose any risk. Within this period the UHB have an opportunity to engage with staff and where necessary retrain to ensure that segregation on the ward and in clinical areas is undertaken in line with the guidance provided. Incineration of waste is considerably more costly than heat treatment and the UHB and in particular the Capital, Estates and Facilities (CEF) budget will incur an additional £50k/month as a result of the non-conformities.

Discussions with the Clinical Boards and in particular the Directors of Nursing with the Waste Management lead will be arranged to agree the most appropriate way to engage with the relevant parties to ensure that waste is managed appropriately at all levels. One option that should be considered is the appointment of 'Green Champions' at Clinical Board or Directorate level to focus on reducing waste, improving re-cycling and promoting the importance of segregation. The designated person would report into the environmental steering group chaired by the Director of Capital, Estates & Facilities which meet on a quarterly basis as part of the requirement to maintain ISO 14001 Environmental Management accreditation.

At the end of the 3 month period, the contractor will undertake a further audit to ensure the UHB are adhering to the requirements. CEF will request that the contractor undertake the audit at Ward level so that we are able to identify any specific areas of non-compliance.

The All Wales waste contract, is procured and managed by NWSSP, and is due to end in May 2025. However, the Clinical Waste Consortium which represents all Health Boards within the contract have undertaken an option appraisal to determine whether to re-tender at this stage or enact the extension allowable under the existing agreement. The outcome of the appraisal is to agree the extension until May 2027.

General, Recycling & Food Waste:

Cardiff City Council provide the service for general, food and re-cycling directly to the UHB with the current contract due to expire in February 2023, and have expressed their intention not to offer the UHB the option to extend the contract.

We are currently in the process of working with our procurement colleagues, to award a commission to a new service provider for this contract.

Tenders have been returned and are currently being evaluated, to identify the preferred supplier, following which the relevant approvals will be sought to enable the awarding of the contract at a value of circa £560k per annum.

Health & Safety:

The Waste Management team are continually looking to improve the level of service provided and in particular with the Health and Safety standards operating across the service. The department have recently introduced a formal Health & Safety group which meets on a regular basis and includes representatives for the waste operatives, who are best placed to highlight the daily risk encountered.

Unfortunately, in early December 2022 there was an incident in the Waste Yard at the University Hospital of Wales, in which one of the Waste team was injured and taken to the Emergency Unit for treatment. A waste bin appeared to have fallen off the back of the Contactors vehicle (SRCL) which hit the member of staff on the head/shoulder area rendering him unconscious. The gentleman injured was released following examination in EU and is recovering at home. The incident was reported as a RIDDOR event to the HSE

The incident is being investigated by the Corporate Health & Safety Team, with support from the CEF assurance team. Following the completion of the investigation and on receipt of the report CEF will in discussion with H&S colleagues review any recommendations and implement accordingly.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- It is expected that cost increases will continue to be seen across all waste collection services, including the move from public to private sector collections for general, recycling and food waste disposal, with potential further increase from increase in fuel prices.

- An incident which occurred in the waste yard in December 2022 is being investigated by the UHB Corporate H&S team with any recommendations to be reviewed and implemented as appropriate

Recommendation:

The Health and Safety Committee are requested to:

a) NOTE the content of the report recognising the increased waste being managed and the increased costs associated with the increased demand and fuel costs;

b) SUPPORT the proposal for discussions with the Clinical Board Directors of Nursing to ensure that waste is separated appropriately at Ward/department level and that the correct procedures for waste disposal is adhered to when disposing of waste within areas. Staff should also be advised of the cost implications of non-compliance;

c) SUPPORT the appointment of 'Green Champions' from the Clinical Boards/Directorates to raise the awareness of waste and its impact on the environment, with aim of reducing waste, increasing re-cycling and ensuring safe and appropriate disposal; and

d) NOTE the RIDDOR reportable incident and the ongoing investigation by the Corporate H&S team.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes
(1) Reportable incident under investigation (2) separation of waste at ward level

Safety: Yes
Inappropriate waste separation can put staff at harm from sharps or contaminated waste

Financial: Yes
Increased waste and non-compliant separation have financial implications

Workforce: Yes/No

Legal: Yes	
Statutory compliance	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: Yes	
Incineration of wastes causes increased carbon	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Ventilation Annual Report				Agenda Item no.	7.8	
Meeting:	H&S Committee		Public	X	Meeting Date:	17/01/2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Finance						
Report Author (Title):	Head of Estates.						

Main Report
Background and current situation:

Background

The purpose of the Report is to provide the H&S Committee with assurance that the ventilation systems at Cardiff & Vale UHB are maintained and inspected, in accordance with the guidance Welsh Health Technical Memorandum (WHTM) 03-01 parts A and B. As part of the requirement the UHB have appointed an Authorised Engineer (AE) for ventilation to provided support and guidance to the UHB Approved Persons, one of which has recently been appointed with another progressing through the training and assessment process. It is also planned for a further 2 staff to be trained during 2023 to enhance the team further. The AE also provides advice periodically on the suitability of systems as well as undertaking the annual audits.

It is important to note that where a ventilation plant identified as critical air plant, under the WHTM, and independent verification of this system is required and is undertaken by a specialist company who act independently of both the UHB and the AE.

Current situation

The AE undertook an audit in May 2022, the outcome of which was 4 recommendations for consideration/action. Capital Estates and Facilities (CEF) have produced an action Plan (appendix 1) which indicates the management response/action, current status etc.

CEF have also re-established the Ventilation Safety Group to oversee all aspects of ventilation across the UHB estate. In addition to Clinical Board representation, Infection, Prevention and Control (IP&C) are a key member to the group. IP&C work closely with Estates and Capital colleagues to manage ventilation systems.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Re-establishment of the Ventilation Safety Group

The CEF assurance & Compliance team have contracts in place for the maintenance of all air plant, including filter changes

Critical air plant identified in conjunction with the Service Boards is verified on an annual basis as required under the WHTM.

The ventilation policy is in draft form for approval at next ventilation safety group then ratification in 2nd quarter 2023

Recommendation:

The Committee is requested to**:**

a) NOTE the content of the report and the progress made in response of the recommendations;

b) NOTE the re-establishment of the Ventilation Safety Group; and

c) NOTE that critical air plant as identified in the WHTM have annual independent verification checks undertake to ensure compliance

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: Yes/No NO
Equality and Health: Yes/No NO
Decarbonisation: Yes/No NO

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Appendix 1 ventilation action plan

The key findings

No of Recs	Recommendation Narrative/inspection outcome	Operational Lead	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update	Target date for completion
1 of 4	**VENTILATION ANNUAL REPORT:** The health boards ventilation policy needs to be completed and submitted to the board for approval.	Director of Capital Estates and Facilities	partially	The ventilation Policy is in draft format and is being tabled at the next ventilation safety group for passing. In the 2nd quarter 2023 it will be presented for ratification subject to any alterations.	June 2023
2 of 4	**VENTILATION ANNUAL REPORT**: At least one additional AP(V)' should be appointed at each hospital to provide some resilience.	Director of Capital Estates and Facilities	partially	1 AP formally appointed for health board UHB wide. 1 AP currently going through process and familiarity, with 2 further planned for training in early 2023. 1 new employee planned to undertake training and assessment	Completed June 2023 December 2023
3 of 4	**VENTILATION ANNUAL REPORT:** To comply with the new version of HTM 03-01 Parts A & B (2021), the list of critical ventilation systems at C&VUHB hospitals needs to be reviewed and updated to include for all critical ventilation systems, including imaging facilities, dental	Director of Capital Estates and Facilities	partially	List of critical plant has been circulated to ventilation group for inclusion in the maintenance regime in line with ventilation policy and is agenda item at meetings. Local extract ventilation list to be completed at next ventilation safety group and discussed with the authorising Engineer.	March 2023

	treatment rooms and local extract ventilation (LEV) systems				
4 of 4	**VENTILATION ANNUAL REPORT**: The attendance and frequency of meetings of the Ventilation Safety Group (VSG) needs to improve during 2022. VSG meetings should be at least quarterly and all relevant stake holders should be encouraged to attend the meetings regularly. This includes senior representatives from IP&C, microbiology, theatre managers, clinical / nursing, health and safety, estates	Director of Capital Estates and Facilities	partially	Meetings diarized and list of attendees sent invites, minutes and papers. As per recommendation, representation from across the Clinical Boards are requested to attend. Chair and Vice chair in place from Capital Estates & Facilities	Completed March 2023

Report Title:	Medical Gas pipeline systems				Agenda Item no.	7.9
Meeting:	H&S Committee		Public	X	Meeting Date:	17/01/2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Director of Finance					
Report Author (Title):	Head of Estates					

Main Report
Background and current situation:

Background

The purpose of the Report is to provide the H&S Committee with assurance that the Medical Gas Pipeline systems (MGPS) at Cardiff & Vale UHB maintained and inspected in accordance with Welsh Health Technical Memorandum (WHTM) 02-01 parts A and B. As a requirement of the WHTM, the UHB have appointed an independent Authorising Engineer (AE) to oversee the training, appointment of Approved Persons (AP) and system audits. The AE is commissioned from National Wales Shared Services Partnership, Specialist Estate Services (SES) and provides support and guidance on the compliance with HTM guidance.

Current situation

The AE undertook an annual audit of the Medical Gas Pipeline Systems across the UHB 2021(the report does not indicate an exact date), with 13 recommendations identified. Capital, Estates & Facilities Service Board have developed an action plan (Appendix 1) which provides the management response/actions, together with the current progress against each recommendation.

CEF have experienced difficulty in recruiting trade staff over recent years which has impacted their ability to train suitably competent AP's, although in recent months 3 members of staff have been assessed and appointed by the AE. The UHB also benefit from the appointment of a senior member of the estates team to the role of coordinating AP.

The pharmacy department have a key role in the management of the medical gas services including oversight of medical gas procurement and the testing of new or altered pipework systems.

The UHB has re-established its medical gas committee to oversee all aspect of the installation and purchase of medical gas across organization.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- The difficulties in the recruitment of suitable trade qualified staff to provide the key role of AP across the sites
- The progress made to train staff who have successfully completed their assessment to become AP's across the UHB Sites

Recommendation:

The Committee is requested to:

a) **NOTE** the content of the report and the progress made against each of the recommendations resulting from the audit; and

b) **NOTE** the re-establishment of the Medical Gas Committee to oversee the safe management of the Medical Gas systems

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration	x	Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Appendix 1 ventilation action plan

The key findings

No of Recs	Recommendation Narrative / Inspection outcome	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update	Target date for completion
1 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Nominate for assessment and appoint coordinating / senior MGPS APs' and additional MGPS APs' to provide suitable cover, once suitable training and site familiarity is achieved	partially	Head of Estates appointed as Coordinating AP for UHB. 2 APs appointed for UHL 1 AP appointed UHW. 4 Further APs in progress and due for assessment January/February 2023 with Others completed the course and are gaining site familiarity before consideration of assessment later in year.	completed completed completed 31st May 2023 1st October 2023
3 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Ensure suitable AP support, management and governance arrangements are put in place	completed	Formalisation and mentoring by coordinating AP overseeing all MGPSs works across the UHB and supported by Estates compliance and project manager**.**	completed
4 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Develop the MGPS committee and ensure relevant personnel are in attendance	completed	Medical Gas committee established and led by head of Pharmacy, meetings held regularly with cross section of representation from UHB.	completed
5 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Ratify and implement an up-to-date MGPS Operational	Partially	Medical Gas Policy is in draft form and is a topic of MGPS committee discussion for alterations and ratification by all.	June 30th 2023

	Policy and procedural documents.			
6 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Emergency preparedness documents should also be developed to sit under the policy, with particular reference to oxygen alerts and pandemic responses.	Partially	Forming part of the policy via the committee for inclusion.Aps receive alerts currently from the AE and act accordingly.	June 30th 2023
7 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Determine St David's PFI operating procedures	Partially	Lines of responsibility have been determined, St David's has its own Authorising Engineer and uses A 3RD party contractor for its AP coverage of the Site. St David's procedures to be included in policy.	Completed 30th June 2023
8 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Asset tagging of all items of MGPS plant and equipment is recommended, with full inventories/database constructed. This methodology will help ensure all consumable items of plant are changed in line with manufacturer's guidance, and all items of plant changed in line with pressure regulations and insurance inspector's recommendations.	Partially	Working through process off adding to database, checking pressure regulations data and coordinating how to maintain supplies whilst changing valves.	September 2023
9 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Once an asset register is completed it is recommended	Partially	List of assets already in the system and schedules in place for maintenance via a 3rd party specialist maintenance contractor. All plant is maintained and	September 2023

	that a full PPM review is carried out for all the MGPS assets, and a full list of maintenance requirements developed for all sites to ensure correct checks, tests are programmed as per guidance tabled in HTM 02-01.		some are being upgraded in 2023. All line valves are listed in the APs key cabinets	
10 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Ensure that written schemes of examination are in place for those relevant to the MGPS under the terms of the Pressure Systems Safety Regulations 2000 an asset data base system for each site would help in this regard.	completed	Insurance systems are in place via a portal with British Engineering, currently being managed by Estates compliance and project manager**.**	completed
11 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Train and appoint sufficient Designated Nursing/Medical (DNO/DMO) officers, and Designated Porters.	Partially	Raised as an item at MGPS committee as an item for action. Porters previously had training on safe bottle handling/storage.	December 2023
12 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Ensure there is a training program for all staff using medical gasses	partially	Raised at medical gas committee for action, discussion around how and who to deliver training.	December 2023
13 of 13	**MEDICAL GAS PIPELINE SYSTEM:** Health board cylinder management requires improvement	partially	Pharmacy taking initiative and are in the process of trialing at UHL a bar coding system in conjunction with BOC at UHL. This will enable cylinders to be tracked and once trial completed a recommendation/proposal will be submitted.	May 2023

Report Title:	Low Voltage System Report				Agenda Item no.	7.10	
Meeting:	H&S Committee		Public	X	Meeting Date:	17/01/23	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Finance						
Report Author (Title):	Head of Estates						

Main Report
Background and current situation:

Background

The purpose of the Report is to provide the H&S committee with assurance that the low voltage systems at Cardiff & Vale UHB are maintained and inspected in accordance with the guidance document Welsh Health Technical Memorandum (WHTM) 06-02 parts A and B to ensure that the systems remain safe. In many cases the systems do not comply with BS7671 (18th Edition) Wiring Regulations and Capital Estates & Facilities (CEF)have included a number of items on their Risk Register.

In accordance with the HTM guidance Cardiff and Vale UHB have an appointed independent Authorising Engineer (AE) to provide advice and guidance to the UHB. The AE assess the Approved Persons and undertakes the system audits. The AE service is currently provided by National Wales Shared Services Partnership, Specialist Estate Services (SES).

Current situation

Following the annual audit undertaken by the AE in February 2022, there were 5 recommendations for areas of improvement. CEF have reviewed the findings of the report and produced an action plan (appendix 1), which identifies the management response and current status of the recommendations.

To review progress with the recommendations and to ensure that risks are appropriately monitored, an Electrical safety group has been established which will report to the CEF Health & Safety Group.

As part of the process to ensure that the Electrical infrastructure across the sites operates effectively in the event of a mains failure, the UHB is in the process of planning a 'Black Start' at UHW in June 2022. This exercise has not been undertaken on the UHW site for many years and to comply with the HTM should be undertaken annually with the emergency generators suppling the load for circa 4 hours.

A project team, chaired by the Director of CEF has been established with a number of sub groups leading in specific areas to ensure that risk on the actual day of the test is minimized. The project team have presented the proposals to the Operational Planning Group with further meetings planned.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- Difficulty in recruiting competent staff to train as AE's has been difficult in the current climate
- The age of the electrical switchgear and distribution network is of concern as parts are becoming more difficult to procure
- The UHB plan to undertake a 'Black Start' in June 2022 with significant planning required to mitigate associated risk

Recommendation:

The Board / Committee are requested to Note:

the content of the report and the progress made in addressing the recommendations of the audit.

the establishment of a UHB electrical safety group

the risk associated with the age and obsolescence of the infrstructure

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration		Collaboration		Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: YES

Associate with age of equipment which is both non-compliant and becoming obsolete

Safety: Yes/No YES

The age of the equipment has caused issues and in relation to safe working practices and overheating potentially causing fire

Financial: YES

Parts periodically have to be manufactured specifically for the system and are more costly. To replace the system or parts thereof will be significant and disruptive to the service

Workforce: Yes

Recruitment of competent staff

Legal: No

Reputational: No

Socio Economic: NO

Equality and Health: NO

Decarbonisation: Yes/No NO

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

Appendix 1 ventilation action plan

The key findings

No of Recs	Recommendation Narrative/inspection outcome	Operational Lead	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update	Target date for completion
1 of 5	**Low Voltage Authorised Person: -insufficient numbers**	Director of Capital Estates and Facilities	partially	4 appointed APs Training of others in process to meet the required standard.	Complete September 2023
2 of 5	**Low Voltage** Authorised person do follow the procedure for safety documentation for all job types as set within the WHTM06-02	Director of Capital Estates and Facilities	complete	All APs passed refresher training. Procedures in place and weekly Audits in place. Operational procedure manual now in place.	Complete Complete
3 of 5	**Low Voltage** Competent Person: - low numbers	Director of Capital Estates and Facilities	partially	CP training course booked for January 2023 to cover a further 12 delegates.	31st March 2023
4 of 5	**Low Voltage Switch rooms: -** Secure access	Director of Capital Estates and Facilities	partially	All dedicated LV switch rooms have unique key. Shared rooms being looked at sub dividing. Roll out of Estates CLIQ key in 2023	Complete 30th April 2023 December 2023

5 of 5	**UPS & Generator Systems: -** maintenance /testing	Director of Capital Estates and Facilities	partially	Ups systems on maintenance contract. Generators tested weekly off load Plans for black start to run all generators on load 2023.	Completed June 2023

Report Title:	Sharps Management Policy			Agenda Item no.	8.1
Meeting:	Health and Safety Committee	Public	X	Meeting Date:	17th January 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Director of People and Culture/Director of Nursing				
Report Author (Title):	Assistant Head of Health and Safety				

Main Report
Background and current situation:

The Health Board is committed to ensuring safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013.

The Health Board shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.

The Health Board will substitute traditional, unprotected medical sharps with a 'safer sharp' where it is reasonably practicable to do so. If a suitable safer sharp is not available to reduce the risk of injury, the Health Board will ensure that safe procedures for working and disposal of the sharps are in place.

The Health Board fully supports the introduction of devices with engineered safety mechanisms to reduce incidents of needlestick injuries. Staff are expected to use safety lancets, safety cannulas, safety hypodermic needles or other devices with engineered safety mechanisms.

Conventional needles should only be used in exceptional circumstances and a Risk Assessment for each activity/procedure where non safety sharps are used must be completed, recorded and regularly reviewed.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Recommendation:

The Health and Safety Committee are requested to:

- **APPROVE** the Sharps Management Policy and Procedure (UHB 269).

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
No
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
No
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Reference Number: UHB 269 **Version Number:** 3	**Date of Next Review:** **Previous Trust/LHB Reference Number:** *N/A*

SHARPS MANAGEMENT POLICY

Policy Statement

The Health Board is committed to ensuring safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013.

The Health Board shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.

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The Health Board fully supports the introduction of devices with engineered safety mechanisms to reduce incidents of needlestick injuries. Staff are expected to use safety lancets, safety cannulas, safety hypodermic needles or other devices with engineered safety mechanisms.

Conventional needles should only be used in exceptional circumstances and a Risk Assessment for each activity/procedure where non safety sharps are used must be completed, recorded and regularly reviewed.

Policy Commitment

The 2010/32/EU directive has been introduced in order to prevent injuries and the risk of blood-borne infection to healthcare workers from sharps instruments such as needles.

The purpose of the Directive is to implement the Framework Agreement to ensure that injuries of workers by all medical sharps (including needlesticks) are prevented to protect workers at risk and to establish procedures in risk assessment, risk prevention, training, information awareness and monitoring.

It is the responsibility of all Health Board employees to be aware of and adhere to this Policy within the remit of the Health and Safety at Work Act 1974.

Supporting Procedures and Written Control Documents

This Policy and the Infection Control Standard Precautions Procedure describe the following with regard to Sharps Safety.

- Roles and Responsibilities
- General Arrangements – Sharps Management
- Training
- Reporting of Sharps Injuries
- Monitoring and Measuring Performance

This Policy is supported by the following documents:

- Health and Safety Policy
- Infection Control Standard Precautions Procedure
- Incident, Hazard and Near Miss Reporting Policy
- Risk Assessment and Risk Register Procedure
- Waste Management Policy

Scope

This policy applies to all staff in all locations including those with honorary contracts

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a no impact.
Policy Approved by	Health and Safety Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Director of Nursing/Director of People and Culture

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
2	July 2017		Reviewed and updated in line with departmental and reporting structure changes

3	January 2023		Reviewed and updated in line with departmental and reporting structure changes

Equality & Health Impact Assessment for

SHARPS MANAGEMENT POLICY

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objective of the policy is to ensure safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013. The Health Board shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.
4.	Evidence and background information considered. For example • population data	Considered all staff groups that could come into contact with sharps – clinical and non clinical staff.

	• staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet).
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	All UHB Staff and those with honorary contracts

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There does not appear to be any impact	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the policy would be made accessible to staff and service users in alternative formats on	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
medical conditions such as diabetes	request or via usual good management practice.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff or service users regarding gender.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	There appears not to be any impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There appears not to be any impact on staff regarding race, nationality, colour, culture or ethnic origin.	Whilst there doesn't appear to be any impact, if a member of staff or service user was known to have difficulties with the	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers		written word, good management would dictate that alternative arrangements be made, such as individual meetings. Translators would be used where necessary to communicate with service users.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There appears not to be any impact.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless,	There appears not to be any impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
people who are unable to work due to ill-health			
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to take into account with regard to this Policy.		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	**N/A**	N/A	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels,	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
job security, working conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality	N/A	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	**N/A**	N/A	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	**N/A**	N/A	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities, however, it is suggested that implementation of the policy will have a positive impact on the safety and wellbeing of UHB staff, Patients and Visitors.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No Actions			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	N/A			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Approve Policy as there are no significant negative impacts.			

Reference Number: UHB 269 Version Number: 2	Date of Next Review: Previous Trust/LHB Reference Number: N/A

Sharps Management Procedure

Introduction and Aim

The aim of this Procedure is to support the Sharps Management Policy to provide effective safe management of sharps. In particular the need to assess the risks, provide appropriate information and training in consultation with Health Board staff, patients and any other users of Health Board premises/services.

Objectives

The Objectives of the procedure are to:-

- Comply with the legal duties in relation to protection against sharps injuries placed on the UHB by the following:-

  Health and Safety at Work etc Act 1974
  Management of Health and Safety at Work Regulations 1999
  Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
  Control of Substances Hazardous to Health Regulations 2002
  Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

- To ensure there are adequate first aid facilities and competent response for staff that maybe injured at work within the UHB.

- Effectively manage Safer Sharps provision through the risk assessment process and appropriate control measures

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts.

Equality Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.*
Documents to read alongside this Procedure	Sharps Management Policy Health and Safety Policy Infection Control Standard Precautions Procedure Incident, Hazard and Near Miss Reporting Policy Risk Assessment and Risk Register Procedure Waste Management Policy
Approved by	Operational Health and Safety Group/Health and Safety Committee

Accountable Executive or Clinical Board Director	Director of Nursing/Director of People and Culture
Author(s)	Assistant Head of Health and Safety

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*Health and Safety Committee July 2017*	*01 September 2017*	*New UHB format of Policy and Procedure*
2	*Health and Safety Committee*		

Contents **Page No**

1 ROLES AND RESPONSIBILITIES

1.1 Chief Executive - the Health Board's Health and Safety Policy sets out the responsibilities for Chief Executive, Executive Directors, Managers, Employees and Working Groups for all health and safety policies, procedures and working guidelines, and has the same relevance to this procedure.

1.2 Director of Nursing has delegated responsibility for ensuring:

- This procedure is appropriately disseminated throughout the Health Board.
- The approach to the provision of safer sharps is both systematic and appropriate.

1.3 Executive Directors, Clinical Board Directors, Clinical Board Managers, Clinical Board Nurses, and Directorate Managers must ensure that this procedure is followed in all areas under their control, and ensure that adequate resources are made available to implement this procedure effectively.

1.4 Clinical Leads

The use of non-safer sharps is only permitted if a suitable safer sharp is not available, or a risk assessment demonstrates that there is a clear clinical reason why a safer sharp cannot be used.

The Clinical Leads for each Clinical Board are responsible for ensuring that where a safer sharp is not being used a risk assessment has been carried out and that these risk assessments are reviewed and updated as necessary.

1.5 Line/Departmental Managers

The Line Manager will be responsible for ensuring that a 'Safer Sharps' risk assessment is undertaken wherever clinical activity involves the use of sharps.

This should include the selection of equipment and the safe placement of sharps containers in addition to ensuring correct assembly and disposal.

Line managers shall investigate the circumstances and causes of any incidents and take action required to prevent reoccurrence, ensuring

that a risk assessment is conducted and subsequently safe systems of work are devised and implemented within their area.

1.6 Procurement Department

The Procurement Department is responsible for ensuring:

- That appropriate safer sharps are procured.
- The withdrawal from service of non-safety sharps where appropriate alternatives have been identified.
- Those mechanisms are in place to ensure non-safety sharps are not procured, where there are agreed safer alternatives.
- The procurement department would be responsible to maintain records of usage, by department of safety and non-safety sharps and provide reports to the health and safety department on this data.

1.7 The Learning Education and Development Department shall be responsible for:

- Maintaining a record of Mandatory Training in Infection, Prevention and Control.

1.8 Health and Safety Department

The Head of Health and Safety shall be responsible for:

- Providing advice and information with regard to potential hazards in the workplace.
- Advising on methods of risk assessment.
- Monitoring and reviewing this procedure and advising on the UHB's position with regard to compliance with the Regulations and Guidance.

1.9 Occupational Health Department

The Occupational Health Department shall be responsible for:

- The provision of an appropriate vaccination programme for those staff at risk of sharps injury.
- Ensuring the provision of post exposure and any follow up treatment service.

1.10 Infection Prevention and Control

The Infection Prevention and Control Department shall be responsible for:

- The preparation and delivery of the protocol for needlestick and similar sharps injuries.
- For the preparation and delivery of standard precautions procedure.

1.11 Employees

All employees have a responsibility to:

- Be aware of the necessary action to take in the event of a sharps injury as per the information in the Infection Control Protocol for Needlestick and Similar Sharps Injures.
- Familiarise themselves with this procedure regarding the management of sharps and relevant procedures/protocols.
- Adhere to safe working practices in order not to harm either themselves or others.
- Inform their Line/Department Manager and First Aider/Appointed Person of any conditions that would personally affect their ability to be treated.
- Ensure all incidents of sharps injury are reported in accordance with the UHB Incident, Hazard and Near Miss Reporting Policy and reported via Datix Cymru Reporting system.
- Undertake mandatory infection prevention and control training.

2 GENERAL ARRANGEMENTS - Sharps Management

2.1 Avoidance

Line Managers should review practices to eliminate or reduce unnecessary use of sharps, this includes the use of needle free equipment such as catheter bags and not re-sheathing needles.

2.2 Use of Safer Sharps

Where it is not reasonably practical to avoid the use of medical sharps, the use of safer sharps incorporating a protection mechanism must be used where it is reasonably practical to do so, e.g. safety lancets, safety cannula, safety needles etc. The following factors should be considered:

- The device must not compromise patient care;

- The reliability of the device;
- The care giver should be able to maintain appropriate control over the procedure;
- Other safety hazards or sources of blood exposure that use of the device may introduce;
- Ease of use;
- Is the safety mechanism design suitable for the application - i.e. if activation of the safety mechanism is straightforward, it is more likely to be used.

In some exceptional circumstances the use of safer sharps, such as in Paediatrics, may not be possible. In these circumstances only a needle and syringe or butterfly can be used and a documented risk assessment must be in place to justify this procedure.

2.3 Prevention of recapping of needles

Needles must not be recapped after use unless a risk assessment has identified that recapping is required to prevent a risk.

2.4 Place secure container and instructions for safe disposal close to work area

Provide information and training to staff

This should include:

- Risks of injuries
- Good practice in preventing injury
- Benefits and drawbacks of vaccination
- Support available if injured
- The correct use of safer sharps
- Safe use and disposal of medical sharps
- What to do in the event of a sharps injury
- Arrangements for health surveillance

2.5 Safety Precautions when Using and Disposing of Sharps

Safer sharp devices should be stored separately from any non-safety sharp devices in the area.

Staff involved in providing care should adhere to hand decontamination and use standard precautions to include the use of gloves and aprons in conjunction with the safe use and disposal of sharps. For some procedures i.e mass vaccinations the appropriateness of wearing of gloves can be determined via risk assessment.

Select the relevant size **and colour** of sharps container most appropriate to your needs. Refer to waste guidance if necessary.

Discard sharps directly into a sharps container **immediately after** and **at the point of use.**

Do not re-sheath a needle.

Dispose of needle and syringe as a complete unit – never detach unit by hand unless a risk assessment has been completed.

Do not pass sharps directly from hand to hand, or pass to another person, handling should be kept to a minimum. **The passing of sharps directly hand to hand to another person should be kept to a minimum, using a container such as a kidney dish whenever practicable.**

2.6 Sharps Container

All staff must ensure that:

- Containers are **correctly** and **securely** assembled (follow manufacturers' instructions).
- The label is completed fully to identify date of assembly - this also identifies source and enables an audit trail.
- When not in use (between treatment sessions) containers should be stored with the lid in the 'temporary closed' position to prevent spillage of sharps if the container is knocked over.
- Dispose of container when it is three-quarters full (shown by a "fill line" on each container), ensure secure closure and locking and ensure the label is fully completed. Sharps bins **should never** be placed in any waste bags or waste bins other than those designated for the collection of full rigid sharps containers prior to their consignment for disposal.
- Fluids of any sort are not discharged into bags or containers.
- Containers are not stored on the floor.
- Avoid prolonged use of sharps containers - maximum period of use is three months.
- Always store in a safe designated secure area i.e. in a locked area. Containers should never be placed in corridors or areas with access to the general public unless a specific risk assessment identifies the need.
- Sharps containers that are used at multiple sites and used by community teams should never be left at a patient's home.

- A sharps container that is left at patients own home for their own use needs to be risk assessed and consideration taken for positioning and storage.
- Whenever possible when a sharps container is not in use it should be stored securely/wall mounted to prevent risk of spillages.
- Ideally the sharps container should be taken to the point of care (unless this is identified as a risk) to ensure that the sharp is disposed of immediately following use.
- Disposal of sharps containers to be completed safely in accordance with Health Board procedures.

2.7 Information

The Sharps Regulations require the Health Board to provide health and safety information to staff. The information provided must cover:

- The risks from injuries involving medical sharps
- Relevant legal duties on staff
- Good practice in preventing injury
- The benefits and drawbacks of vaccination

3 TRAINING

- Training will be given to all staff in the use of safer sharps devices in use within their work area.
- Staff will receive training on the safe disposal of medical sharps and what to do if they receive a sharps injury.
- Training will be determined upon the level of risk that has been identified by the risk assessment.
- All staff must undertake Mandatory Infection Prevention and Control training on appointment and every two years.
- Training for those responsible for undertaking assessments will be undertaken as part the UHB programme of “Risk Assessment Competent Persons” courses.

4 REPORTING

All incidents of sharps injuries or near misses must be reported on Datix Cymru Reporting system. In the event of a needlestick or similar sharps injuries they must also be reported to the Occupational Health Department.

5 COMMUNICATION

Line Managers will be responsible for ensuring that staff are informed of the arrangements made in connection with the provision of Safe

Sharps Management on recruitment and periodically throughout their employment.

Notices of the location of first aid boxes and who the designated first aider is for the area shall be posted at prominent locations throughout the area.

The requirements of the procedure shall be cascaded down to staff through the Clinical Board's Health and Safety and Quality, Safety and Experience Groups.

6 MONITORING AND MEASURING PERFORMANCE

Senior Managers, supported by Staff Health and Safety Representatives, will carry out monitoring of this procedure at annual intervals.

Safer Sharps arrangements for each area will be monitored as part of the UHB's Workplace Joint Health and Safety Audit Inspection Schedule.

The performance outcomes will be monitored by the Operational Health and Safety Group/Infection Prevention and Control Group and measured in line with the UHB Health and Safety Policy and reviewed on a regular basis.

7 REVIEWING THE PROCEDURE

The Procedure will be reviewed within three years of implementation or as the Health Board changes and/or when legislation, codes of practice and official guidance dictate.

Report Title:	**Health and Safety Committee Terms of Reference and Work Plan for 2023-24**			Agenda Item no.	8.2
Meeting:	Health and Safety Committee	Public	x	Meeting Date:	17th January 2023
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Director of Corporate Governance				

Main Report
Background and current situation:

It is good governance and good practice for Committees of the Board to review their Terms of Reference on an annual basis. It is also important for Committees to have an appropriate plan of work in place to provide assurance to the Board that all areas detailed within the Terms of Reference are reviewed and considered.

The attached Terms of Reference for the Health and Sub Safety Committee and associated Work Plan (Appendix 1 and Appendix 2) were last reviewed by the Committee in January 2022.

Having up to date Terms of Reference and a work plan in place helps to mitigate the risk to Health and Safety and ensures that the People and Culture Committee and the Board receive appropriate assurance on the statutory requirements of Health and Safety within Cardiff and Vale University Health Board.

Changes to the Terms of Reference since the last review are detailed in red for ease of reference. It should also be noted that a key change to the Terms of Reference is that going forward the Committee will report into the People and Culture Committee and will be a Sub Committee of the Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Health and Safety Committee was a non-statutory Committee of the Board and going forward it will be established as a Sub Committee of the People and Culture Committee in order to scrutinise and provide assurance to the Board on the Health and Safety function within Cardiff and Vale Health Board.

Recommendation:

The Health and Safety Committee are requested to:

(a) **Ratify** the changes to the Terms of Reference 2023-24 and associated Health and Safety Sub Committee Work Plan 2023-24 for the Health and Safety Sub Committee; and
(b) **Recommend** to the Board, for approval, that the Health and Safety Committee will become a Sub Committee of the Board reporting into the People and Culture Committee.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: ~~Yes~~/No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: Yes/~~No~~

The establishment of the Health and Safety Sub Committee will help provide the People and Culture Committee and the Board with the assurance on health and safety activities within the organisation

Financial: ~~Yes~~/No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: ~~Yes~~/No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: Yes/~~No~~

Health and Safety is a statutory function of the Health Board.

Reputational: ~~Yes~~/No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: ~~Yes~~/No

The Socio Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES]
(If this has been addressed in the main body of the report, please confirm)

Equality and Health: ~~Yes~~/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
Useful guidance on the completion of an EHIA can be found at the following link: [EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)]
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: ~~Yes~~/No

If appropriate, has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.
(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Health and Safety Committee	17th January 2023

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Health and Safety Sub Committee

Terms of Reference

Reviewed by the Health and Safety Committee:
17th January 2023

Approved by the Board:

HEALTH AND SAFETY COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The Cardiff and Vale University Health Board (UHB) Standing Orders provide that: "The Board may and, where directed by the Welsh Government must, appoint Committees or sub Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a sub committee to be known as the Health and Safety Sub Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The organisation has a statutory obligation by virtue of the Health and Safety at Work Act 1974 to establish and maintain a Health and Safety Committee:

- "Section 2 sub section 7 : "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".

2. PURPOSE

2.1 The purpose of the Health and Safety Sub Committee ("the Committee") is to:

Advise and assure the People and Culture Committee, the Board and the Accountable Officer on whether effective arrangements are in place to ensure organisational wide compliance of the UHB Health and Safety Policy, approve and monitor delivery against the Health and Safety Priority Improvement Plan and ensure compliance with the relevant Standards for Health Services in Wales.

This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

2.2 Where appropriate, the Committee will advise the People and Culture Committee, the Board and the Accountable Officer on where and how, its Health and Safety management may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the People and Culture Committee, the Committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective Health and Safety function encompassing:

- Staff Health and Safety

- Premises Health and Safety
- Violence and Aggression (inc. Lone Working and Security Strategy)
- Fire Safety
- Risk Assessment
- Manual Handling
- Health, Welfare, Hazard Substances, Safety Environment
- Patient Health and Safety – Environment Patient Falls, Patient Manual Handling
- Staff healthy lifestyle/health promotion activities
- Staff health and well-being

3.2 The Committee will support the People and Culture Committee with regard to its responsibilities for Health and Safety:

- approve and monitor implementation of the Annual Health and Safety Priority Improvement Plan;
- review the comprehensiveness of assurances in meeting the People and Culture Committee, Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non clinical;
- the consideration and approval of policies as determined by the People and Culture Committee.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- objectives set out in the Health and Safety Priority Improvement Plan are on target for delivery in line with agreed timescales;
- standards are set and monitored in accordance with the relevant Standards for Health Services in Wales
- proactive and reactive Health and Safety plans are in place across the UHB
- policy development and implementation is actively pursued and reviewed
- where appropriate and proportionate, health and safety incident and ill health events are investigated and action taken to mitigate the risk of future harm
- reports and audits from enforcing agencies and internal sources are considered and acted upon
- workforce, health, security and safety issues are effectively managed and monitored via relevant operational groups
- employee health and wellbeing activities are in place in line with the UHB commitment to be a public health practicing organisation and corporate health standards
- employee health and safety competence and participation is promoted
- decisions are based upon valid, accurate, complete and timely data and information

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.6 The Chair of the Health and Safety Sub Committee shall have reasonable access to Executive Directors and other relevant senior staff.

3.7 The Head of Health and Safety shall have unrestricted access to the Chair of the Health and Safety Committee

Sub Committees

3.8 The Committee may, subject to the approval of the UHB Board, establish fsub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.9 There are no formal Sub-Committees of the Health and Safety Sub Committee but the Committee will receive copies of the minutes of the Operational Health and Safety Group, Fire Safety Group, Security and Personal Safety Strategy Group and the Water Safety Group as part of its assurance framework.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) Members, comprising:

Chair	Independent member of the Board.
Vice Chair	Independent member of the Board.
Members	A minimum of 1 other Independent member of the Board

Attendees

4.2 The following officers to be in attendance:

- Executive Director of People and Culture (Executive Lead)
- Director of Corporate Governance
- Executive Director of Public Health
- Head of Health and Safety
- Director of Capital, Estates and Facilities
- Assistant Director of Patient Safety and Quality
- Chair of Staff Health and Safety Group plus 2 other staff Health and Safety representatives

- Director, Occupational Safety, Health and Environment Unit, Cardiff University
- Community Health Council representative

Other Directors or nominated deputies should attend from time to time as required by the Committee Chair.

4.3 By invitation:

The Committee Chair may extend invitations to appropriate persons to attend Committee meetings as required from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

Secretariat

4.4 Secretary: as determined by the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Assembly Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair.

Support to Committee Members

4.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for committee members in conjunction with the Director of Workforce and Organisational Development.

5. SUB COMMITTEE MEETINGS

Quorum

5.1 At least two Independent Members one of which must be the Chair of Vice Chair of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year and otherwise as the Chair of the Committee deems necessary – consistent with the UHB's annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may require any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens. The Committee is accountable to the Board via the People and Culture Committee for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the People and Culture Committee on the Sub Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;

- bring to the People and Culture Committee specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example, AGM, or to community partners and other stakeholders, where this is considered appropriate, for example, where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Sub Committee's performance and operation including that of any sub committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- **Quorum**
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed on an annual basis by the Sub Committee with reference to the People and Culture Committee and the Board.

Health and Safety Committee Work Plan 2023-24					
App. -Approval Assurance - Ass. Information - Inf.	**Exec Lead**	**18/04/2023**	**18/07/2023**	**17/10/2023**	**16/01/2024**
Agenda Item					
Standard Items					
Health and Safety Priority Improvement Plan	EDPC	Ass.	Ass.	Ass.	Ass.
Fire Safety and Enforement Report	EDPC	Ass.	Ass.	Ass.	Ass.
Environmental Health Inspector Report	EDPC	Ass.	Ass.	Ass.	Ass.
Enforcement Agencies Report	EDPC	Ass.	Ass.	Ass.	Ass.
Waste Management Compliance Report	EDPC		Ass.		Ass.
Lone worker Report (Including Security Strategy)	EDPC	Ass.		Ass.	
Regulatory and Review Body Tracking Report	EDPC	Ass.		Ass.	
Risk Register for Health and Safety	EDPC	Ass.	Ass.	Ass.	Ass.
Staff Health and Wellbeing	EDPC		Ass.		Ass.
Standards for Health Services in Wales relevant to Health and Safety	EDPC	Ass.			
Strategies					
Health and Safety Strategy	EDPC	App.			
Annual Reports					
Health and Safety Annual Report	EDPC		App.		
Fire Safety Annual Report	EDPC			App.	
Policies					
Health and Safety policies (as and when required)	EDPC				
Health and Safety Overarching Policy	EDPC			App.	
Governance					
Annual Work Plan	DoCG				App.
Self assessment of effectiveness	DoCG		Ass.		
Induction Support for New Committee Members (as and when required)	DoCG				
Review Terms of Reference	DoCG				App.
Produce annual Health and Safety Committee Annual Report	DoCG				App.
Minutes of Health and Safety Committee Meeting	DoCG	Ass.	Ass.	Ass.	Ass.
Action log of Health and Safety Committee Meeting	DoCG	Ass.	Ass.	Ass.	Ass.
Minutes from Other Committees which report into H & S Committee	DoCG	Inf.	Inf.	Inf.	Inf.

Report Title:	Draft Health and Safety Annual Report 2022/23			Agenda Item no.	8.3
Meeting:	Health and Safety Committee	Public	X	Meeting Date:	17/01/2023
		Private			
Status *(please tick one only)*:	Assurance		Approval	X	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Corporate Governance Officer				

Main Report
Background and current situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

The purpose of the Annual Report is to provide Members of the Health and Safety Committee with the opportunity to discuss the attached draft annual report before being submitted to the Board for approval by the end of March 2023.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Committee has achieved an overall attendance rate of 75% from the period 1 April 2022 to 31 March 2023 and has met on four occasions during the year.

The attached Annual Report 2022/23 of the Health and Safety Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Committee is requested to:

a) **REVIEW** the draft Annual Report 2022/23 of the Health and Safety Committee; and

b) **RECOMMEND** the Annual Report to the Board for approval.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Annual Report of Health and Safety Committee 2022/23

1.0 Introduction

In accordance with best practice and good governance, the Health and Safety Committee (the Committee) produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 Membership

The Committee membership is a minimum of three Members. In order for the meeting to be quorate two Independent Members (one of whom must the Committee Chair or the Vice Chair) must be present. Meetings are also attended by the Executive Director of People and Culture, who has assumed responsibility as the Executive Lead for Health and Safety, the Executive Director of Public Health, the Director of Capital, Estates and Facilities, the Director of Corporate Governance, and the Head of Health and Safety. Staff Safety Representatives also attend the meeting. Other Executive Directors are required to attend on an ad hoc basis.

3.0 Meetings and Attendance

The Committee met four times during the period 1 April 2022 to 31 March 2023. The Health and Safety Committee achieved an attendance rate of X% during the period 1 April 2022 to 31 March 2023 as set out below:

Commented [SM(aVU-CG1]: To be completed after January committee meeting

	19/04/2022	19/07/2022	18/10/2022	17/01/2023	Attendance
Mike Jones (Chair)	Y	Y	Y	X%	X%
Akmal Hanuk	N	N	Y	X%	X%
Michael Imperato	N	N	Y	X%	X%
Ceri Phillips	Y	Y	Y	X%	X%
Total	50%	50%	100%	X%	X%

Commented [SM(aVU-CG2]: To be completed after January committee meeting

4.0 Terms of Reference

The Terms of Reference *were reviewed and recommended for Board approval by the Committee on the 17 January 2023*. The Terms of Reference are due to be considered by the Board for approval on 30 March 2023.

Commented [MD(aVU-CG3]: To confirm following January's H&S Committee meeting.

5.0 Work Undertaken

As set out in the Committee Terms of Reference the purpose of the Committee is to:

a) Provide assurance to the Board and the Accountable Officer that there are effective arrangements in place to ensure organisational wide compliance of the UHB Health and Safety Policy;

b) Approve and monitor delivery against the Annual Health and Safety Priority Improvement Plan and ensure compliance with the relevant Standards for Health Services in Wales;

c) Review the comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the UHB's activities, both clinical and non-clinical in relation to Health and Safety;

d) Consider and approve policies as determined by the Board;

e) Provide assurance that:

- objectives set out in the Health and Safety Priority Improvement Plan are on target for delivery in line with agreed timescales;
- standards are set and monitored in accordance with the relevant Standards for Health Services in Wales;
- proactive and reactive Health and Safety plans are in place across the UHB;
- policy development and implementation are actively pursued and reviewed;
- where appropriate and proportionate, health and safety incident and ill health events are investigated and action taken to mitigate the risk of future harm;
- reports and audits from enforcing agencies and internal sources are considered and acted upon;
- workforce, health, security and safety issues are effectively managed and monitored via relevant operational groups;
- employee health and wellbeing activities are in place in line with the UHB commitment to be a public health practising organisation and corporate health standards;
- employee health and safety competence and participation is promoted; and
- decisions are based upon valid, accurate, complete and timely data and information

There were a number of standing agenda items discussed at every Committee meeting which included:

Health and Safety Overview, Fire Safety Updates, Enforcement Agency Reports, Waste Management Compliance Reports, Risk Register for Health and Safety, Regulatory Tracking Reports, Health and Safety Related Policies, Minutes from the Operational Health and Safety Group and Environmental Health Inspection Reports.

During the financial year the Committee reviewed, amongst other items, the following key matters at its meetings: -

Health & Safety Overview

At each meeting, the Committee received a comprehensive verbal update from the Head of Health and Safety. Some of the matters received and discussed by the Committee under this agenda item are set out below.

19 April 2022

At its meeting in April, the Committee was advised that: -

(i) two Assistant Heads of Health and Safety had been introduced to the Health and Safety department.
(ii) The Health Board was due to mark World Safety Day on 28th April 2022. It was an international campaign to promote safe, healthy work around the globe.
(iii) The new Datix Cymru System was due to "go live" date on 1st March 2022.

The Committee was also provided with an update on the draft Health and Safety Culture Plan.

19 July 2022

The Committee received an update regarding an NWSSP audit which had been undertaken to evaluate the adequacy of systems and controls in place with Health and Safety in response to an external review undertaken in 2021. Many of the recommended actions had been incorporated into the Health Board's three-year Health and Safety Culture Plan. Substantial Assurance had been provided.

The Committee was also informed that a new H&S Share Point site was available to staff and included topics, such as manual handling and fire safety management.

18 October 2022

The Committee was informed that a number of incidents involving staff smoking and/or vaping on site, had taken place. The Committee discussed that the Health Board should take a "zero tolerance" approach where staff are found to be smoking in hospital settings, and that the Health Board's No Smoking Policy should be robustly enforced. Actions agreed by the Committee to combat this issue, included (i) urgently referring the matter to the Senior Leadership Board for immediate action, and (ii) convening an urgent meeting with the Committee Chair, the Executive Director of People and Culture, the Executive Director of Public Health and the Head of Health and Safety. Following those meetings, a number of actions (including better signage and increased communication campaigns) were put into place.

The RACI (Responsible, Accountable, Consulted, Informed) matrix had been developed and was due to be rolled out to the Clinical Boards. The RACI document set out the unambiguous ownership of responsibilities in relation to Health and Safety and was due to be presented to the Senior Leadership Board.

17 January 2023

Commented [SM(aVU-CG4]: To be added after January committee meeting

Fire Safety Report

During the year, the Committee was informed of, and discussed, the following fire safety matters:

Fire Enforcement Notice – At its meeting in April the Committee was advised that the Head of Health and Safety and the Head of Estates and Facilities had met with South Wales Fire and Rescue Service enforcement team on 8th February 2022 regarding an Enforcement Notice against the A4 Ward in UHW. It was noted that it was difficult work to complete as the Ward needed to be taken out of service. At its meeting in July, the Committee was informed that the A4 Ward had been closed to allow the work to take place. In October, the Committee members were advised that the compliance date for the outstanding actions has been extended to 31 March 2023. The Head of Health and Safety requested that the Ward was brought out of service in order to get the remaining actions from the Enforcement Notice completed.

Fires at Hafan Y Coed - Another fire had taken place at Hafan Y Coed on 23rd January 2022. The Head of Health and Safety, the Executive Director of People and Culture and the Chief Executive Officer met with the Chief Fire Officer of South Wales Fire and Rescue Service on 23rd March 2022 to discuss the Enforcement Notice issued last year. It was noted that no prosecution decision was made in that meeting but both parties were willing to work closely together. The attendees of that meeting had also fed back to the senior managers in the Mental Health Clinical Board on 25th March 2022 in order to reaffirm the actions that had been put in place to control ignition sources. In addition, the Committee was advised that the following actions had been implemented: -

i. a designated Fire Safety Officer had been assigned to the Mental Health department. It was hoped that this role would be located in Hafan Y Coed. The role would also provide support to other Mental Health facilities such as Barry Hospital and Pendine. The designated Fire Safety Officer would report into Health and Safety department and would remain independent of Mental Health.
ii. A specific Mental Health Fire Safety training course had also been developed.
iii. The Mental Health department was also looking to implement full body scanners.

Unwanted Fire Signals – At the Committee meeting held on October, it was noted that 196 unnecessary fire service calls had been made to date and the Fire Service had attended the Health Board site on 158 occasions. That represented a 30%

increase in the last 3 months, with many of those calls being largely avoidable and attributed to behaviour.

Fire Prosecution Update **–**

Commented [SM(aVU-CG5]: To include a short paragraph following January's committee meeting.

17 January 2023

Fire Safety Compliance Report

18 October 2022

The Committee were informed that the Fire Safety Week was due to run from 17 – 21 October 2022 and mass "drop in" training sessions for staff had been arranged.

Environmental Health Food Hygiene Report

19 April 2022

The Committee noted that during February 2022 both the ward-based catering service and Aroma Coffee units at University Hospital Wales had been inspected. Both achieved a food hygiene score of 5 and 4 respectively. It was an improved score since both food businesses were last inspected, most markedly ward-based catering whose food hygiene rating score had increased from 3 (satisfactory) to 5 (very good).

19 July 2022

The Committee noted that the Environmental Health team had identified some issues with the central processing unit and that they were being addressed and were being tracked on the Regulatory Compliance Tracker.

The Barry Hospital ward-based catering service had received a five-star food hygiene score following an inspection in June 2022.

18 October 2022

The Environmental Health Inspector Report highlighted that four units (Hafan Y Coed at UHL, the Teddy Bear Nursery at UHW, UHL's main kitchen, wards and restaurant, and Aroma at UHL) had recently been inspected and all had achieved a food hygiene score of 5.

Enforcement Agencies Report

19 April 2022

The Committee was advised that: -

(i) There had been a request for information from the Health and Safety Executive (HSE) regarding maintenance and agreements of T2 UHW animal house ventilation. A response had been sent to the HSE.

(ii) The Health Board had not received any further enforcement notices from the South Wales Fire and Rescue Service (SWFRS), although two had remained open. Those two notices related to (1) a failure to adequately control ignition sources at Hafan Y Coed, and (2) insufficient fire controls (such as fire dampers and fire and smoke resisting doors) at Ward A4 in UHW.

19 July 2022

The Enforcement Agencies Report received by the Committee highlighted that the actions relating to T2 UHW Animal House ventilation and UHW theatre trolleys had been addressed by the Health Board and were awaiting sign off from the Head of Health and Safety.

The two SWFRS fire enforcement notices at Hafan Y Coed and Ward A4 in UHW had remained open.

(1) Hafan Y Coed – the Head of Health and Safety had assigned a Fire Safety Officer to e based at Hafan Y Coed.

(2) Ward A 4 - The Head of Health and Safety had received confirmation from SWFRS that the compliance date of 6th April 2022 would be extended to 31st March 2023 to enable the outstanding actions set out in the enforcement notice to be completed. The Committee was advised that the works required to A4 had been brought forward on the Capital, Estates and Facilities Ward Improvement Programme and that the A4 Ward was due for a refit that year.

17 January 2023

Commented [SM(aVU-CG6]: To be added after January's committee meeting

Waste Management Compliance Report

In July 2022, the Committee noted that Internal Audit had undertaken a Waste Management Compliance Audit to assess the Health Board's compliance with the relevant waste management legislation and guidance and to monitor the Health Board's progress towards national and local waste reduction targets. Reasonable Assurance was provided.

Regulatory and Review Body Tracking Report

This was a standard report which came to the Committee twice a year to track the reports and information regarding inspections undertaken by various inspection/review bodies as a key source of assurance.

At its April meeting, the Committee received a report which provided information for the period 1st April 2021 – 31st March 2022 and included a summary of five Health and Safety Executive (HSE) inspections undertaken during that period.

The Committee received a further report in October 2022 which highlighted two further HSE inspections had taken place and the requested information had been sent by the Health Board to the HSE.

Risk Register for Health and Safety

In line with the Health Board's Risk Management and Board Assurance Framework Strategy, the Health and Safety Department is required to maintain and review a risk register which sets out identified strategic and operational risks that have the potential to impact upon the delivery of the Health Board's strategic objectives. At each of its Committee meetings, the Committee received and discussed the Risk Register for Health and Safety.

As at the Committee meeting in January 2023, the highest current risk rating was xxxx and related to xxxxxx.

Commented [MD(aVU-CG7]: To confirm following January's meeting.

Health and Safety Culture Plan 2022-2025

In July, the Committee was provided with an update in relation to the Health and Safety Culture Plan, namely that: -

(i) the 2022-2025 Health & Safety Culture Plan was a three-year project with specific objectives that would drive the necessary improvements in H&S across the Health Board;

(ii) it had superseded the H&S Priority Improvement Plan; and

(iii) it was due to be presented to July's Board for formal approval.

Standards for Health Services in Wales relevant to Health and Safety

At is meeting in April, the Head of Health and Safety advised the Committee that the Standards for Health Services in Wales which were relevant to Health and Safety had been considered by the Health and Safety team and no relevant changes were required.

Health and Safety Annual Report 2021-2022

In July, the Committee received and discussed the Health and Safety Annual Report for 2021-2022. That Annual Report provided an overview of the breadth of work undertaken by the Health and Safety team and provided assurance that areas of high priority had been identified and were being managed during a particularly challenging time for all UK Health Boards given the COVID-19 global pandemic.

Policies

The Committee received and approved the following policies during the year, namely: -

19 April 2022 - Latex Allergy Policy and Procedure

17 January 2023 – Sharps Management Policy and Procedure

Commented [MD(aVU-CG8]: To be confirmed following January's meeting.

The Committee has reported to the Board after each of the Health and Safety Committee meetings by presenting a summary report of the key discussion items at the Health and Safety Committee. The report is presented by the Chair of the Health and Safety Committee.

6.0 Opinion

The Committee is of the opinion that the draft Health and Safety Committee Report 2022/23 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Mike Jones - Chair of the Health and Safety Committee

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MINUTES OF THE OPERATIONAL HEALTH AND SAFETY GROUP 09:00 on the 6th September 2022 via MS TEAMS

Attendance

Present:

Robert Warren	Head of Health and Safety
Rachael Daniel	Assistant Head of Health and Safety
Rachael Sykes	Assistant Head of Health and Safety
Jonathan Davies	Health and Safety Advisor
Matthew Howells	Deputy Directorate Manager AWMGS
Sue Bailey	Clinical Board Director for Quality, Safety & Patient Experience – CD&T Clinical Board
Stephen Gardiner	Head of Estates and Facilities – CEF Service Board
Kirsty Hook	Risk, Governance & Patient Experience Facilitator – Children and Women Clinical Board
Emma Stone	Health and Safety Lead - Dental Directorate
David Pitchforth	Lead Nurse Integrated Medicine – Medicine Clinical Board
Daniel Crossland	Head of Operations – Mental Health Clinical Board
Nicola Bevan	Head of Occupational Health
Claire Main	Interim Director of Nursing for Specialist Services
Janice Aspinall	Lead Staff Safety Representative
Jonathan Strachan-Taylor	Staff Safety Representative
Carolyn Alport	Quality and Safety Clinical Nurse Lead – Surgery Clinical Board
Theresa Blackwell	Business Manager – PCIC Clinical Board
Helen Luton	Interim Director of Nursing – Orthopaedics
Karen Lewis	Head of Personal Injury Claims
Hannah Phillips	Acting Head of Personal Injury – Legal and Risk Services NWSSP
Elliot-James Gyphion	Paralegal - Legal and Risk Services NWSSP

Apologies:

Rachel Gidman	Executive Director of People and Culture
Jon McGarrigle	Head of Energy and Performance
Rachel Thomas	Assistant Director of Operations – Planning and Delivery – PCIC Clinical Board
Caroline Murch	Health and Safety Advisor

In Attendance:

Thomas Bott	Administrative Support

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OHSG/06/09/22/001	**Welcome and Introductions** The Head of Health and Safety welcomed all to the meeting and apologies were received and noted.
OHSG/06/09/22/002	**Minutes from Previous Meeting** The minutes of the meeting held on the 6th of June 2022 were received and accepted as a true record.
OHSG/06/09/22/003	**Action Log** The action log was received and noted by the group.
OHSG/06/09/22/004	**Health and Safety and Regulatory Update** The Head of Health and Safety provided an update to the group. Mr Warren informed the group the health and safety trainers had recently been re-accredited for delivering violence and aggression, manual handling and 1st aid training by external providers. Mr Warren advised some concerns had been raised that the lone worker devices' GPS system was being used to track staff, he stressed the GPS system was not accessible to individual managers, and was used for specific situations such as genuine alarms, police involvement or lost devices. It was noted there had been an increase in compliance across the health and safety training modules. Mr Warren advised there had been a number of notable incidents since the last meeting, these being: (1) A calibration cylinder was inappropriately disposed of, this has now been closed out with mitigation being brought in, in relation to detailed disposal instructions. (2) The fire escape outside PETIC in UHW was being blocked on a regular basis and physical preventions were now being put into place due to behavioural controls failing. Mr Warren updated the group in respect of fire safety. He informed the group that Mr Mal Perrett had sadly passed away and condolences had been sent to his family. (1) A4 North was currently being refurbished with a plan to then refurbish A4 south, this was to respond to the compliance notice issued by South Wales Fire and Rescue Service.

	(2) A meeting was to take place with SWFRS in respect of the letter under caution issued by them in relation to ignition sources in Hafan-y-Coed. (3) Mr Warren reported that an arson incident had been started by unknown individuals at Malefa, Llanrumney which was actioned correctly by staff. (4) Provisional dates for fire safety training week 17th - 21st October although there were some difficulties in obtaining suitable venues, as soon as the dates were confirmed they would be widely communicated throughout the Health Board. In respect of HSE actions previously reported to the group responses were still awaited in respect of T2 and Theatres, UHW.
OHSG/06/09/22/005	**Feedback from Health and Safety Committee** The Head of Health and Safety informed the Group there was no specific feedback from the Committee and any relevant issues would be discussed as part of this agenda.
OHSG/06/09/22/006	**Clinical Boards Health and Safety Group Feedback** The Head of Health and Safety thanked the Clinical/Services Boards for submitting their exception reports. In general, he noted there was an increase in violence and aggression incidents and difficulties in obtaining data for lost time incidents would need to be further explored. The Clinical/Service Boards then provided their feedback: The Deputy Directorate Manager for AWMGS reported gas cylinders were being replaced with gas piping, once implemented this would lower the risk. Two colleagues have recently completed the NEBOSH General Certificate with a view to developing the health and safety culture within AWMGS. The Governance & Patient Experience Facilitator – Children & Women Clinical Board advised there were no major issues to raise, however Mrs Hook wished for it to be noted there were 2 further RIDDORs to be added to the report, this was due to late reporting, these were both as a result of slips, trips and falls. The Clinical Board Director for Quality, Safety & Patient Experience – CD&T reported 1 RIDDOR in the period which had not been included in the report. A particular issue for the Board was in relation to pigeons and their associated risks and expressed her thanks for the support received from CEF. With respect to incident investigations Mrs Bailey considered that following up on incidents was helpful in reinforcing shared learning. Mrs Bailey informed the group this was her last meeting as she was retiring and introduced Mrs Helen Luton who would be replacing her. Mr Warren thanked Mrs Bailey for her commitment and support to health and safety and wished her well in her retirement, this was echoed by the group.

	The Health and Safety Lead - Dental Directorate reported fit testing was still on-going within the Dental Hospital. Miss Stone advised the directorate were experiencing some challenges in respect of verbal aggression and the de-escalation of such events. She also raised the servicing of the ferno evacuation chairs was currently out of date. Mr R Warren advised he would discuss this with the fire safety team. **Action – Mr R Warren** The Lead Nurse Integrated Medicine, Medicine Clinical Board reported health and safety meetings for the Board were being reintroduced following an absence due to covid demands. Mr Pitchforth highlighted patient and staff safety risks in MEAU and ED due to overcrowding, he also advised being unable to access training courses was also a risk for the Board. Mr Pitchforth raised concerns there was currently hover jack availability issues in UHW and Mr R Warren confirmed that funding had been approved to purchase a replacement hover jack. The Head of Operations – Mental Health Clinical Board reported the main issues were smoking, fire and violence & aggression. He added the new smoking restrictions may pose some difficulties for the Clinical Board but were being appropriately addressed. The Interim Director of Nursing for Specialist Services reported work was on-going within the Board to improve complex patient handling. Mrs Main advised they were currently dealing with a number of estate issues and thanked CEF for their response and support. She also advised there had been incidents of staff falling due to equipment being left in inappropriate places and this was being addressed through shared learning. The Quality and Safety Clinical Nurse Lead – Surgery Clinical Board reported a number of estate issues including leaks in multiple theatres and entrance lighting for SSSU. Mrs Alport reported a capital bid had been declined for the refurbishment of theatre changing rooms due to cost related issues and was looking for some support to progress this, both Mr Warren and Mrs Aspinall advised they would be happy to provide support and would discuss outside of the meeting. **Action – Mrs C Alport/Mr R Warren/Mrs J Aspinall** The Head of Estates and Services – CEF Service Board apologised for not submitting a written report. In respect of the estate issues raised by the Clinical Boards he would follow these up with the individuals concerned. The Business Manager for PCIC Clinical Board apologised for the late submission of the report. She advised the Clinical Board were also working with estates to address their on-going issues. Ms Blackwell reported the fire alarm sounded in CRI but not in the out of hours office which posed a risk

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	for staff working in this area, this had been brought to the attention of the fire safety team.
OHSG/06/ 09/22/007	**RIDDOR Incidents** This item was addressed through the Clinical/Service Board exception reports.
OHSG/06/ 09/22/008	**Staff Side Issues** The Lead Staff Safety Representative informed the group of the services provided by staff side safety. Mrs Aspinall had no specific issues to raise.
OHSG/06/ 09/22/009	**Personal Injury Claims Update** The Head of Personal Injury Claims introduced Ms Phillips from NWSSP and explained they would be alternating meetings so that the group could receive both local and all wales information. Ms Phillips advised she had been working on CAV cases since the beginning of the year but was working closely with a colleague who had been aligned to the Health Board for 10 years who had a vast knowledge of the cases submitted over the years. She presented the reports to the group explaining current categories and thresholds, however there were no major concerns for the Health Board.
OHSG/06/ 09/22/010	**Health Issues** The Head of Occupational Health provided a verbal update to the group and reported there had been an increase in the number of referrals which were now higher than pre-pandemic levels, and the complexity of the referrals had also increased quite significantly. Mrs Bevan advised all wales occupational health had created a number of wellbeing risk assessments which were being shared with the all wales health and safety managers. Mrs Bevan informed the group the staff flu campaign commences mid-September and strongly encouraged staff to attended their covid and flu vaccine appointments. Occupational health will also be holding sessions for staff to have these vaccines alongside the vaccination centres.
OHSG/06/ 09/22/011	**Fire Safety Report** The Head of Health and Safety advised fire safety issues had been covered in agenda item OHSG/06/09/22/004.
OHSG/06/ 09/22/012	**Health and Safety Training Update** The Assistant Head of Health and Safety (RS) reported training was being prioritised for new staff being recruited through a number of Health Board

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	initiatives but gave assurances that the department was delivering training to the resources available. Mrs Sykes advised the MHWCA programme continued to receive positive feedback, but unfortunately following the pilot Healthcare Support Workers (HCSW) would not be accepted in this role due to scope of practice in line with the HCSW framework.
OHSG/06/ 09/22/013	**PPE Cell Update** The Health and Safety Adviser (JD) reported there were no PPE issues and the continuity of supply for RPE was being provided. Mr Davies reported the health and safety department continue to offer fit testing on Tuesdays and Wednesdays and also continue to provide fit tester training.
OHSG/06/ 09/22/014	**Staff Covid Cases and Issues** The Head of Health and Safety queried whether the group had any concerns or issues in relation to staff covid infections or any other airborne illnesses, none were raised. Mr Warren informed the group a meeting would be arranged with Infection Prevention Control to discuss airborne infections in general and how these should be assessed.
OHSG/06/ 09/22/015	**Policy and Procedure – Approvals and Reviews** The Head of Health and Safety noted there were no policies or procedures for review.
OHSG/06/ 09/23/016	**Any Other Business** The Head of Personal Injury Claims advised she found the exception reports to be very useful especially for shared learning.
OHSG/06/ 09/22/017	**Date and Time of Next Meeting** The next meeting will be held at 9.00am on Tuesday 29th of November 2022 via Teams.