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Case No: 202200339 A3

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM SOUTHWARK CROWN COURT
HIS HONOUR JUDGE TOMLINSON
T20200060

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17 November 2022

Before :

LADY JUSTICE CARR
MRS JUSTICE MAY
and
HIS HONOUR JUDGE EDMUNDS KC

Between :

LONDON FIRE COMMISSIONER

Respondent

- and -

BUPA CARE HOMES (ANS) LTD

Appellant

Mr Richard Matthews KC & Ms Eleanor Sanderson (instructed by **Browne Jacobson LLP**)
for the **Appellant**
Ms Saba Naqshbandi & Ms Genevieve Woods for the **Respondent**

Hearing date: 9 November 2022

Approved Judgment

This judgment was handed down remotely at 10am on Thursday 17 November 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Lady Justice Carr :

Introduction

1. This is a renewed application by Bupa Care Homes (ANS) Ltd (“BUPA”) for leave to appeal against sentence imposed on 5 January 2022 by HHJ Tomlinson (“the Judge”) sitting in the Crown Court at Southwark. BUPA was prosecuted by the London Fire Commissioner (“the LFC”) for breaches of the Regulatory Reform (Fire Safety) Order 2005 (“the FSO”) following the death of Mr Cedric Skyers (“Mr Skyers”) on 13 March 2016 at one of its many care homes. Following an unsuccessful application to dismiss, BUPA pleaded guilty on a basis which was not accepted by the LFC. The Judge conducted a *Newton* hearing and, on the basis of his findings, proceeded to impose a fine of £937,500 on BUPA, alongside a prosecution costs order in the sum of £104,425.42.
2. The gravamen of BUPA’s application is a challenge to the Judge’s finding that its breaches were causally linked to Mr Skyers’ death. It is said that the Judge was wrong to find i) that safety precautions for smoker residents amounted to a “general fire precaution” within the meaning of the FSO, and ii) that measures requested of smoker residents to reduce fire risk did not amount to aspects of their care and treatment for the purpose of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (“the 2014 Regulations”), such that the residents’ consent was not required. It is also said that the Judge was wrong to find the level of BUPA’s culpability to be high, as opposed to medium. BUPA submits that the appeal would raise important issues relating to the operation and regulation of care homes, including potential conflict between the requirements of regulatory regimes.
3. Unless otherwise stated, references in this judgment to Articles are reference to Articles in the FSO, and references to Regulations are references to Regulations in the 2014 Regulations.

The incident on 13 March 2016: Mr Skyers’ death

4. BUPA operated (and continues to operate) a care home known as Manley Court, John Williams Close, Brockley, London, SE14 5XA (“the Home”). The Home houses approximately 85 vulnerable residents. As at 2016 none was ambulant; all would thus, for example, require assistance to escape in the event of a fire.
5. Mr Skyers had been a resident there since December 2006, having suffered a stroke in his late 50s. He was partially paralysed with left-sided hemiparesis, a wheelchair user, and required 24-hour assistance for daily living. He needed significant care. As well as having severely restricted mobility, he was doubly incontinent. He was unable to brush his teeth unassisted. He also had a degree of cognitive impairment, although he was able within the Home’s caring environment to make many of his own decisions.
6. He was described by a nurse as an “entertaining man who enjoyed chatting with the staff”. He was a known smoker who liked to smoke in the areas outside the Home. He could use his right hand to locate a cigarette in his jacket pocket, place it in his mouth and then use an ordinary gas-propelled light to light up. A registered nurse at the Home had assessed him as a safe smoker.

7. In the mid-morning of 13 March 2016 he was left alone in his wheelchair in an outdoor sheltered area away from the main building. He caught fire whilst smoking a cigarette. A care assistant saw him from the first-floor window, summoned assistance and the emergency services were called. It is not known for how long Mr Skyers had been alight before staff were alerted to the emergency. Tragically, and despite best efforts to extinguish the fire, it was too late to save Mr Skyers. He was 69 years old at the time of his death.
8. Mr Skyers had been prescribed, amongst other things, treatment with a paraffin-based emollient cream. Emollient cream, once administered to the skin, can impregnate clothing, bedding and chairs, thus increasing flammability, and its effects can remain for some time. The evidence suggested that emollient cream had not been applied to Mr Skyers on the day of his death, or in the days immediately preceding it. However, as reflected in the Judge's ruling following the *Newton* hearing, that did not eliminate the possibility of emollient creams playing a part in the conflagration that engulfed him.

Significant previous events

9. The following previous events played a material part in the prosecution and sentencing process:
 - i) BUPA's 2013 national fire safety policy document ("BFM 20") made no reference to fire risks arising out of the use of paraffin-based creams;
 - ii) BUPA issued a Manager's briefing note in April 2015 ("the 2015 briefing note"). By this stage, there was a recognised industry-wide concern about risks from paraffin-based products. On its frontispiece the note stated:

“3. Things that you need to do

...c. Be aware of paraffin-based oils, ointments, creams and sprays”

In the body of the document, section 3c. stated as follows:

“Following the recent fatality of a resident in a non-Bupa care home, we are keen to ensure that all colleagues know that when paraffin based creams, ointments, oils and sprays come into contact with clothing or dressings they become easily ignited by a naked flame.

The risk is even greater when these preparations are applied to large areas of the body, and clothing or dressings become soaked. Clothing and bedding can also become soaked, as can chairs when the paraffin soaks into the fabrics.

Residents must be kept away from fire and flames and warned not to smoke, or suitable precautions must be taken, e.g. the wearing of a smock/apron. We also recommend constant staff supervision.

If a resident wishes to smoke:

- They should be informed of the risk and advised to wear a thick outer covering that has not been contaminated with paraffin based products
 - Consider the use of a fire protective apron or smock
 - Consider changing clothing and bedding more frequently
 - Only allow the lighting of cigarettes with a gas lighter (no matches) – by colleagues only
 - Instruct colleagues not to leave a resident smoking unsupervised
 - Highlight the issue to all colleagues
 - Carry out an individual smoking risk assessment of the resident as normal with the control measures in place.”
- iii) On 1 September 2015 the London Fire Brigade wrote to BUPA reminding it of the risk from fire in all of its care homes and identifying the fire risks for smokers and those with limited cognitive ability or mobility (“the 2015 LFB letter”). The letter referred to the importance of reviewing risk assessments and to a previous death of a care home resident. The particular dangers where residents were known smokers were emphasised. Appropriate control measures and additional equipment to best manage the risk of fire, and support individuals at greater risk, needed to be identified. The first suggested measure was “Supervision of smoking”;
- iv) An October 2015 fire risk assessment (“the 2015 FRA”) identified at the outset that all 85 residents at the Home were non-ambulant. It also identified the risk from paraffin-based products and required a number of steps to be taken in response. Home managers were to ensure that all staff received fire training. It stated (“To be completed by February 2016”):

“It is recommended that the Bupa Fire Manual Note 20 *Smoking* is reviewed and implemented.

Following a number of fatalities in care homes while residents were smoking following the application of paraffin based skin medication it is recommended that all resident smoking risk assessments are reviewed to ensure that the correct protection and procedures are in place.”

The prosecution

10. The LFC raised three charges against BUPA:

- i) Count 1: failure to make a suitable and sufficient risk assessment, contrary to Articles 9(1) and 32(1)(a);

- ii) Count 2: failure to make and give effect to appropriate arrangements for the effective planning, organisation, control, monitoring and review of the preventative and protective measures, contrary to Articles 11(1) and 32(1)(a);
 - iii) Count 3: failure to provide employees with adequate safety training, contrary to Articles 21(1) and 32(1)(a).
11. The indictment period for each count spanned 20 December 2006 to 14 March 2016, mirroring the period of Mr Skyers' residence at the Home.

Dismissal ruling: 26 February 2021

12. BUPA applied to dismiss counts 1 and 2. The crux of the submissions on both counts was that an individual smoking risk assessment ("ISRA") did not lead to the identification of "general fire precautions" (as defined in Article 2 of the FSO by reference to Article 4). Rather, an ISRA could only enable the assessor to identify person-specific safety measures regulated by other authorities, including the Health and Safety Executive ("HSE") and the Care Quality Commission ("CQC"). An ISRA was not required as part of an Article 9 fire risk assessment to identify "preventive and protective measures", nor was it a preventive and protective measure in itself. So BUPA argued:

"Both the fact that such an ISRA identifies only person-specific fire precautions, at most, indirectly related to fire and its spread on the premises, and the fact that a clinical exercise and exercise of judgment are required to undertake an ISRA, determine that ISRAs fall outwith measures to reduce the risk of fire in the premises."

13. The Judge summarised his understanding of BUPA's position as follows:

"The argument is that the [FSO] was never intended to be deployed to prosecute discrete failures to address the minutiae within a specific work setting, but only failures that had they been addressed would have comprised adequate measures and arrangements of general application. So, it is argued, were this prosecution to be allowed to proceed with the indictment in its current form, the implications for carers would be widespread in a way that is unworkable and inimical to the public interest."

14. Having outlined the facts, rehearsed the proposed indictment alongside the relevant Articles, and summarised the "fundamental way" in which the LFC put the prosecution case, the Judge ruled on the application.

15. He noted that BUPA had not correctly understood the LFC's position. On count 1, the LFC's main argument was based on a failure to identify and record in any of the fire risk assessments in 2008, 2014 and 2015 the risks to residents who were vulnerable or especially at risk. On count 2, the prosecution alleged a variety of failings beyond the ISRA, summarised as follows:

- i) to plan "managing smoking risk at the smoking shelter";

- ii) to organise “safe smoking at the premises”;
 - iii) to control “the fire risk associated with unsafe smoking”;
 - iv) to monitor “residents’ use of the smoking area and their safety”;
 - v) to conduct a “review of the preventive and protective measures”.
16. The Judge agreed that a resident’s unique ISRA “would not simply fall within the scope” of Article 9, and that Mr Skyers’ ISRA “would go beyond any ambit of generality”. However, a “general strategy to ensure that those responsible for making ISRAs approach their duty in the right way is quite another matter”. Thus he rejected the submission that no relevant breaches of Article 9 or 11 could be identified.
17. In short, the Judge disagreed that the first two counts on the indictment were misconceived, “though there may well be scope for amendment to their Particulars”. He considered that a series of numbered elements would better inform particularity. He did not consider that a preparatory hearing was necessary.

Guilty plea

18. Following this ruling, BUPA pleaded guilty to count 2 and the LFC did not seek a trial on counts 1 and 3, which were ordered to lie on the file.
19. In its basis of plea, BUPA accepted the following breaches of Article 11 in the following respects: BUPA’s management control of the general fire safety arrangements at the Home was not effective, in that there was a failure fully to implement the contents of the 2015 briefing note regarding paraffin ointments, oils and sprays including:
- i) To ensure that colleagues understood the risks from the use of emollient creams, known to be flammable;
 - ii) To warn residents using paraffin-based products not to smoke or to require the use of precautions, such as the wearing of smocks or aprons;
 - iii) Subject to the resident’s agreement, to instruct colleagues not to leave a resident using a paraffin-based product smoking unsupervised;
 - iv) To carry out an individual smoking risk assessment of the resident as normal with the control measures in place.
20. BUPA also accepted two further failures, namely a failure fully to implement recommendations and consequential remedial actions identified in the 2015 FRA and a failure to ensure that the Home’s manager participated in and completed BUPA’s mandatory fire safety training.
21. BUPA accepted that each of these breaches exposed relevant persons to a risk of death or serious injury in the event of fire on the premises of the Home.
22. The LFC’s position was that precautions, including constant supervision when smoking, were to be taken in respect of residents prescribed paraffin-based creams,

regardless of whether or not a resident was wearing such cream at the time. The resident's consent was not required. Supervision should therefore have been implemented for Mr Skyers. BUPA's breaches caused Mr Skyers' death.

23. BUPA's position was that, notwithstanding that the 2015 briefing note had not been implemented and the smoking risk assessments had not been reviewed in accordance with BFM 20, as recommended by the 2015 FRA, the court could not be sure that these failings had contributed more than minimally to Mr Skyers' death.
24. In these circumstances, it was necessary for a *Newton* hearing to be held.

Newton ruling: 8 December 2021

25. The *Newton* hearing took place on 15 November 2021. The Judge heard evidence from three experts: for BUPA, Mr Colin Todd, a fire safety expert, and Mrs Nadia Jejna, a compliance and governance inspector for BUPA Care Services (Quality and Compliance Team); for the LFC, Mr Mark Hazelton, a specialist in fire safety and community risk reduction. He also received lengthy written and oral submissions. He gave a written ruling dated 8 December 2021, finding in summary as follows.
26. The Judge referred at the outset to his ruling on the application to dismiss and the circumstances of Mr Skyers' death. He stated in bald and clear terms:

“Had someone been nearby to keep an eye on [Mr Skyers] while he was smoking, they would have been able to take appropriate action to save him from serious injury, and quite possibly any injury at all.”
27. Primarily BUPA's management control of the general fire safety arrangements at the Home failed because, through management, it did not fully implement the contents of the 2015 briefing note which plainly drew attention to – and was designed to draw attention to – the risks involved when paraffin-based ointments, oils and sprays are prescribed and provided to vulnerable non-ambulant persons to ease the skin complications that arise through the inactive sedentary lifestyle that their disability imposes on them.
28. BUPA emphasised many times that the failure was one of making and giving effect to sufficient arrangements, as in management systems. BUPA submitted that the LFC wrongly conflated “arrangements” with “precautions”. It was argued that the measures which should have been implemented were not “general fire precautions within the FSO, but rather individual, case-specific, clinical measures for the resident personally”. That led to the further qualification that consent of the individual resident in each case was required. BUPA also accepted a failure fully to implement items and remedial actions as identified in the 2015 FRA, and that its monitoring and review arrangements failed to ensure that the Home's manager participated in and completed BUPA's mandatory fire safety training.
29. On the issue of causation, the Judge rejected BUPA's denial of any nexus between BUPA's breaches of Article 11 and Mr Skyers' death. In this regard, he accepted the evidence of Mr Hazelton. Supervision of Mr Skyers was “really” the “key” and “would of course have ensured early detection of the problem long before the point of no

return”. He ruled that “the omission of even maintaining a watch on [Mr] Skyers while he was smoking falls all square within the causation of this accident”:

“To that extent I reject the submission that the failure to react to the [2015 briefing note] played absolutely no part in the events. I cannot accept that the question of supervision was a matter for the smoking assessment of the individual on a case specific basis...”

30. That said, this was not a case of corporate manslaughter. It was “material” though not “central” to the causation issue that emollient creams may not have played a part in the event, evidenced by the frequency of clothing laundering, reducing the risk of impregnation by emollient creams.
31. As for the argument that Mr Skyers’ wish to smoke unsupervised may have been a factor, to which Mrs Jejna’s evidence was primarily geared, he was unimpressed by her evidence. Her evidence did not recognise adequately the contrast between a person who can smoke unaided and a person who can smoke unsupervised. The Judge stated (at [11]):

“I cannot accept that any resident at Manley Court, sharing his general characteristics to a greater or lesser degree, could have been left to smoke unsupervised: nor can I accept that a decision in that regard would be a mere matter of a clinical judgment.”
32. The Judge found that the recommendations in the 2015 briefing note and the 2015 FRA were of general application. He again accepted the evidence of Mr Hazelton over that of Mr Todd, agreeing that Mr Hazelton had properly assessed the position that should have prevailed, regardless of any potential ISRA (falling outside the scope of the FSO) that would have provided additional safety.
33. His approach on sentencing would be that there were two essential factors: first, an “inadequate understanding” by management that emollient cream had the potential to impregnate clothing which may become more flammable, despite the “common knowledge” to this effect in 2015; and secondly, an assumption that there was no serious risk of fire outside the main building from smoking, which had not been thought “of, or through, at all”.
34. The Judge then referred back to his dismissal ruling and his comments in relation to the general circumstances surrounding residents’ smoking at the Home and acknowledged BUPA’s understandable respect for the private dignity of residents who had an inalienable right to be treated as adults. That may have contributed to the “rather unscientific, haphazard and ill thought through staff practice of leaving residents to smoke in a wholly unsupervised setting, on the understanding that they could attract their carers’ attention by calling out”. He noted *R (N) v Secretary of State for Health; R (E) v Nottinghamshire Healthcare NHS Trust v Equality and Human Rights Commission* [2009] EWCA Civ 795; [2009] ILR LR 31, where the lawfulness of the “smoke-free policy” implemented at Rampton Hospital was considered.
35. Directly on the issue of consent, the Judge rejected BUPA’s submission, relying upon Regulation 11(1), that the imposition of fire safety requirements by BUPA on residents

at the Home had to be subject to and was dependent upon their express or implied consent.

36. The Judge interpreted “treatment” as it appeared in that context with “care” “to refer more to the physical effort involved in ensuring the health and comfort of the resident”. He commented that almost any medical intervention involves an element of assault to which a patient must consent, including washing and dressing a resident. He doubted whether “care” or “treatment” in Regulation 11 could conceivably extend to maintaining a watch on someone whilst they enjoyed a cigarette:

“Quite simply I do not agree that it was open to [BUPA] to proceed on the basis that any resident had an entitlement, whether express or implied, to withhold his consent to the provisions and recommendations in the [2015 briefing note or the 2015 FRA].”

37. The Judge concluded that he therefore connected at least the failure to implement supervision with the cause of Mr Skyers’ death and was sure that he was applying the law correctly in that regard. Beyond that, and the consent issue, there was little between BUPA and the LFC for sentencing purposes.

The sentence

38. The Judge rehearsed the background and referred back to his earlier rulings for the full detail. He emphasised that the primary factor was that no assessment of residents’ smoking arrangements had been carried out from a health and safety perspective at all. The essence of the offence was that, against a background where most of the Home’s residents shared Mr Skyers’ general level of physical and cognitive impairment, it was wrong to assume that, if a partially paralysed resident could light and smoke a cigarette unaided, they could be left to smoke unsupervised.
39. The Judge adopted the three-step structure identified in the Sentencing Council Guideline for Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences, namely to:
- i) Determine the offence category by reference to harm and culpability;
 - ii) Determine a starting point and category range, focussing on the business’ turnover, with aggravating and mitigating features influencing where in the range the starting point should lie;
 - iii) Verify whether the appropriate fine based on turnover is proportionate to the overall means of the offender, reflecting the economic realities in which the offender currently operates.
40. Whilst the Guideline was not directly applicable, there is rightly no criticism of this approach (see *R v Butt* [2018] EWCA Crim 1617 (“*Butt*”) at [23]; *R v Sandhu* [2017] EWCA Crim 1908 at [21] and [22]).
41. The Judge assessed harm as medium, and not high, because the fire occurred outdoors. There was a “medium likelihood” of death or serious injury. The offence was a

significant cause of Mr Skyers' death and there was a risk of death or serious injury to other vulnerable resident smokers, alongside risks to staff and emergency services.

42. He assessed culpability as high, albeit not "the worst of its kind". He referred to the three separate opportunities in 2015, leading up to Mr Skyers' death, when BUPA missed opportunities to address the fire risks to smokers in its care. Had it reacted appropriately, it would have been routine for a member of staff to maintain a watch on resident smokers in the sheltered area in question. He rehearsed the defence submissions on culpability in detail, interpolating that the experts on both sides were agreed that the omission in BFM 20 of any reference to paraffin-based creams was significant. He referred in detail to the evidence of the defence expert, Mr Todd. In the Judge's assessment, there were two essential factors: a lack of understanding in relation to the risk of fire from the use of paraffin-based emollient creams, despite the warnings in 2015, and a failure to "think through" the risk of fire outside the main building at all.
43. Based on category 2A offending, he increased the figure of £1.1million for a large business to £1.5 million at step 2. He reduced that figure at step 3, to take account of BUPA's overall means and economic position, reaching a figure of £1.25million. To that he applied (what appears to us to be a generous) 25% credit for the guilty plea.

Grounds of appeal

44. BUPA seeks to advance two grounds of appeal, in summary as follows:
 - i) Ground 1: it is said that the Judge erred in determining that the breach of Article 11 was a causative breach of Mr Skyers' death because:
 - a) The Judge erred in finding that safety precautions for individual smoking residents (including one-to-one supervision of a smoking resident) amounted to a "general fire precaution" within the meaning of the FSO:
 - A requirement to supervise all smoking residents with a certain type of disability can only amount to a "General Fire Precaution" if that requirement is (or should have been) generated following a suitable and sufficient risk assessment within the meaning of Article 9;
 - The Judge's test, namely that those sharing the "general characteristics" of Mr Skyers should have constant supervision, is not suitable for determination by such a risk assessment, which is carried out by persons who are not required to have expertise in clinical examination or in the assessment of disabilities. Rather it is a question of necessary fire precautions for those with disabilities of a certain type. Risk assessors are not required to have expertise in clinical examination or assessment of disabilities and should not be charged with the responsibility of assessing what sorts of disability require what types of precaution. Otherwise, the clinical judgments of carers are usurped. Fire safety inspecting officers would have responsibility for determining whether certain types of disability had been assessed correctly, undermining the function of the HSE;

- b) The Judge erred in finding that measures requested of residents to reduce smoking risks did not amount to aspects of their care and treatment, such that their consent was not required for the measures to be imposed:
 - The requirement for consent is a legal requirement, enshrined in Regulations 9, 11 and 12. The Judge’s construction of “care and treatment” was wrong in law. Regulation 12(2) provides examples of what may amount to care, and includes the assessment of risks to those receiving care and treatment, and mitigation of those risks. Regulation 2 provides a narrower interpretation of “personal care”, in line with the Judge’s characterisation of “physical” effort. However, the mandatory terms of Regulation 11(1) and 12(1) apply to the provision of all forms of care. Reliance is placed on a “Brief Guide” issued by the CQC in 2019 (“the 2019 Guide”) which confirms that it considers the management of service users who smoke as falling within the meaning of “care” and thus subject to regulation. If supervision did not amount to “care”, then there would be no requirement for a competent person to perform it. It would not be an activity regulated by the CQC;
 - ii) Ground 2: it is said that the Judge was wrong to find BUPA’s culpability to be high, as opposed to medium:
 - a) The offender was the overarching BUPA company, not the specific care home in question. The expert evidence of Mr Colin Todd was to the effect that there was “ample evidence” of sound fire safety management policies within BUPA as a whole;
 - b) The Judge relied heavily on three warnings in 2015. However, two were issued by BUPA, not to BUPA;
 - c) BUPA’s failings were an isolated aspect of its significant undertaking, in a single location, and due to a local failure to implement measures, despite the existence of a system which mandated such measures.
45. On Ground 1a) Mr Matthews KC emphasised orally the submission that a need for supervision could not be identified without individual assessment of each resident in question, alongside their medical records, prescriptions and care plans. The whole question required a complex exercise of professional judgment. The focus of Article 11 was on “arrangements”; documents such as the 2015 briefing note were not what Parliament had in mind.
46. Mr Matthews also sought to rely on a 2017 Memorandum of Understanding between the HSE and the CQC (“the 2017 Memo”). BUPA sought to rely on an entry in Annex A where, under the heading “Illustrative examples of incidents that fall to CQC and HSE/LAs”, it was suggested that the CQC would take the lead with a CQC-registered provider where:
- “a patient/service user injured during a supervised outing where the carer is employed by a registered service provider”

47. Since Article 47 disapplies the Health and Safety at Work Act 1974 from premises covered by the FSO, it is submitted that whether or not a safety measure falls within the ambit of the FSO is important, since it will determine which regulator has the power to investigate and enforce in relation to it. If a matter falls within the scope of the FSO then the HSE will have no jurisdiction, likewise if it falls to be dealt with by the HSE, then it is not a matter covered by the FSO. (Article 4(2) is the corollary to Article 47, since it excludes from the meaning of general fire precautions “measures.. [which] (a) are designed to prevent or reduce the likelihood of fire arising from such a work process or reduce its intensity; and (b) are required to be taken or observed to ensure any compliance with any requirement of (i) the relevant statutory provisions within the meaning given in Part 1 of the Health and Safety at Work Act ...”)
48. The LFC resists the application, in summary as follows:
- i) Ground 1a): it is said that BUPA is attempting impermissibly to go behind its guilty plea, which accepts that the implementation of the 2015 briefing note was, subject to the disputed issue of consent, a preventive and protective measure within the meaning of Article 2. In any event, the Judge was not considering specific measures directed to an individual resident, but general measures identified in BUPA’s own policy as mandatory for a group of residents sharing certain characteristics. Once it is accepted that, as a matter of law, general fire safety measures for classes of residents are capable of amounting to general fire precautions, the question of whether the safety measures did so in this specific case was a matter of fact for the Judge to decide;
 - ii) Ground 1b): it is said that the Judge was correct to find that supervision while smoking did not amount to “care and treatment” for the purpose of Regulation 11(1). In any event, the question of consent has no bearing on the outcome of the application. Mr Skyers was never asked for his consent to the fire safety measures, and there was no evidence of any refusal on his part to comply with measures in the past;
 - iii) Ground 2: it is said that the Judge clearly took into account the role of BUPA as a broad corporate entity. The three warnings in 2015 were not the only basis for his finding of high culpability, and the warnings were in any event relevant.
49. In her oral submissions, Ms Naqshbandi emphasised in particular the experience of the Judge and his engagement with the facts and detail of the case over the course of a year, in which he presided over three full hearings. This is not a case where this court should lightly interfere with his conclusions and findings.

Discussion

Relevant legislation

50. We turn first to the relevant legislative regime.

The FSO

51. Article 3 identifies who is a “responsible person” for the purpose of the FSO, namely, in relation to a workplace, “the employer, if the workplace is to any extent under his

control”. It is common ground that BUPA, as employer, was the “responsible person” in relation to the Home. The definition in Article 2 of “relevant persons” includes any person who is or may be lawfully on the premises. It is common ground that Mr Skyers was a “relevant person” at the Home, as were his co-residents.

52. Article 5(1) provides that, where the premises are a workplace, the responsible person must ensure that any duty imposed by, amongst others, Article 11, is complied with in respect of those premises.
53. Article 11(1) provides:

“The responsible person must make and give effect to such arrangements as are appropriate, having regard to the size of his undertaking and the nature of its activities, for the effective planning, organisation, control, monitoring and review of the preventive and protective measures.”
54. Article 2 defines “preventive and protective measures” as meaning “the measures which have been identified by the responsible person in consequence of a risk assessment as the general fire precautions he needs to take to comply with the requirements and prohibitions placed on him by or under this Order”.
55. Article 2 defines “risk assessment” as meaning the assessment required by Article 9(1). Article 9(1) provides:

“The responsible person must make a suitable and sufficient assessment of the risk to which relevant persons are exposed for the purpose of identifying the general fire precautions he needs to take to comply with the requirements and prohibitions imposed on him by or under this Order.”
56. Article 8 mandates that the responsible person implements the measures so identified.
57. Article 2 defines “general fire precautions” as having the meaning in Article 4. Article 4(1)(a) provides that “general fire precautions” in relation to premises means “measures to reduce the risk of fire on the premises and the risk of spread of fire on the premises”. Article 4(2) excludes from the meaning of general fire precautions any measures required to be complied with by Part 1 of the Health and Safety at Work Act 1974.
58. By Article 32(1)(a), it is an offence for any responsible person to fail to comply with any requirement (or prohibition) imposed by, amongst others, Article 11 where that failure places one or more relevant persons at risk of death or serious injury in case of fire.
59. Article 47 disappplies the Health and Safety at Work Act 1974, and regulations made under it, to premises covered by the FSO.

The 2014 Regulations

60. BUPA was a “registered person” providing a “regulated activity” for the purpose of the 2014 Regulations, being the provider of personal care services for persons who, by reason of old age, illness or disability, were unable to provide it for themselves and

which services were provided in a place where those persons were living at the time that the care was provided (see Regulation 2 and Schedule 1). Mr Skyers was a “service user”, being a person receiving services provided in the carrying on of a regulated activity (see Regulation 2).

61. BUPA was obliged, by Regulation 8, to comply with Regulations 9 to 19 in providing care at the Home. Regulation 9, headed “Person-centred care”, provides materially:
 - “(1) The care and treatment of service users must-
 - (a) be appropriate,
 - (b) meet their needs, and
 - (c) reflect their preferences.
 - (2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11.”
62. Regulation 11, headed “Need for consent”, provides materially:
 - “(1) Care and treatment of service users must only be provided with the consent of the relevant person.”
63. Regulation 12, headed “Safe care and treatment”, provides materially:
 - “(1) Care and treatment must be provided in a safe way for service users.”
64. Regulation 12(2) goes on to give a non-exhaustive list of things which a registered person must do to comply with Regulation 12(1), including the assessment of risk to the health and safety of service users and doing all that is reasonably practicable to mitigate such risks.
65. “Care” is not defined in the 2014 Regulations but Regulation 2 defines “personal care” as meaning i) physical assistance with eating, drinking, toileting, washing or bathing, dressing, oral care or care of skin, hair and nails or ii) “the prompting, together with supervision, of a person in relation to the performance of any of those activities where the person in question cannot make a decision for themselves in relation to performing such an activity without such prompting and supervision”.
66. “Treatment” is defined (except for persons being detained under the Mental Health Act 1983) as including “a diagnostic or screening procedure carried out for medical purposes”, “the ongoing assessment of a service user’s mental or physical state”, “nursing”, “personal and palliative care”, and “the giving of vaccinations and immunisations”.

Ground 1: general fire precautions

67. As set out above, under Article 32(1), it was an offence for BUPA to fail to comply with Article 11 where such failure placed one or more relevant persons at risk of death

or serious injury in case of fire. It is important to remember throughout that the offence is established by reference to the existence of risk of death or serious injury. Actual death or serious injury is not required, though its incidence may of course illustrate both the existence of the risk and the consequences if the risk is not adequately managed, as the LFC contended that Mr Skyers' death did.

68. The analytical process can be broken down as follows:
- i) Article 11 imposed an obligation on BUPA in respect of the Home to make and give effect to such arrangements as were appropriate, having regard to the size of BUPA's undertaking and the nature of its activities, for the effective planning, organisation, control, monitoring and review of the *preventive and protective measures*;
 - ii) By Article 2, *preventive and protective measures* were the measures which had been identified by BUPA in consequence of a *risk assessment* as the *general fire precautions* necessary for compliance with the requirements of the FSO;
 - iii) By Articles 2 and 9, a *risk assessment* was the risk assessment that BUPA was required to make, namely a suitable and sufficient assessment of the risk to which relevant persons were exposed for the purpose of identifying the *general fire precautions* necessary for BUPA to take to comply with the requirements and prohibitions imposed on it by the FSO;
 - iv) By Articles 2 and 4, *general fire precautions* were measures to reduce the risk of fire on the premises and the risk of spread of fire on the premises.
69. By Ground 1a) BUPA seeks to challenge the fact that the Judge passed sentence on the basis that the safety precautions in question fell within the meaning of the "general fire precautions" to be the subject of a risk assessment as a result of which the preventive and protective measures were to be identified. The Judge found that the safety precautions were not individual or person-specific measures but were general measures, mandatory for a group of residents sharing certain characteristics, which group included Mr Skyers. Thus there was a causal nexus between BUPA's failures and Mr Skyers' death, a factor relevant to the assessment of harm.
70. We make three points at the outset:
- i) There is force in the LFC's submission that, by its guilty plea, BUPA had in fact accepted that both the 2015 briefing note and the 2015 FRA were general fire precautions for the purpose of the FSO. That is because, on at least one legitimate reading of its basis of plea, it accepted in terms that a) in failing fully to implement the contents of the 2015 briefing note and b) in failing to implement actions identified in the 2015 FRA, it breached Article 11;
 - ii) Further, the foundation of Ground 1a) is misconceived. BUPA seeks to contend that the Judge found that safety precautions "for individual smoking residents" amounted to "general fire precautions". The Judge did no such thing. He found that safety precautions for a class of residents at the Home, namely resident smokers for whom treatment with paraffin-based products was prescribed, amounted to general fire precautions;

- iii) Nor was the Judge's classification based on a particular type or degree of disability. That is important, since it reduces, if not eliminates, the relevance of BUPA's submissions made by reference to the suggested need for clinical judgment in any assessment of fire risk.
71. Beyond these matters, it is correct, as BUPA points out, that general fire precautions are defined in the FSO as those matters identified by a fire risk assessment within the meaning of Article 9. It is important to note that an Article 9 risk assessment has to be both "suitable and sufficient". So for example, in terms of suitability and sufficiency, the Judge found in terms that the BFM 20 was insufficient, in that it failed to identify any fire risk arising out of the use of paraffin-based products. Further, it was common ground that ISRAs did not form part of an Article 9 assessment.
72. We do not consider it to be arguable that the Judge was wrong to conclude that an Article 9 risk assessment could properly cover necessary measures to protect and keep safe from fire all smoking residents for whom treatment with paraffin-based products was prescribed.
73. It was open to the Judge to conclude that the precautions identified in the 2015 briefing note and the 2015 FRA were readily capable of amounting to general fire precautions to be identified by a responsible person in consequence of a suitable and sufficient fire risk assessment. That is starkly demonstrated in the 2015 briefing note, where there is a clear and direct instruction that managers needed to take a series of general actions, including the instruction of colleagues not to leave a resident smoking unsupervised. The final instruction in the menu of actions to be taken was to perform an ISRA. Thus the ISRA was in addition to, not in substitution for, the other general steps to be taken.
74. The role of a fire risk assessor carrying out a suitable and sufficient fire risk assessment is to identify hazards and risks, together with necessary precautions, by reference to the nature of the premises and the relevant persons. The identification of precautions, through supervision of resident smokers prescribed treatment with paraffin-based products, did not call for the exercise of any clinical expertise, or the need for a fire risk assessor to consider a resident's detailed medical notes and history. Rather, it was a general aspect of operation at the Home that fire risk assessors would be expected to know about and/or be told of.
75. For the sake of completeness, we should record that we have not been assisted by a consideration of the contents of the 2017 Memo. The 2017 Memo post-dates the indictment period, reflects a private understanding between the two organisations in question, namely the CQC and the HSE, and does not lay down any rigid jurisdictional lines. Further, an incident on care home premises does not fall obviously within the concept of "a supervised outing" as referred to in the Annex in question.
76. Finally, as the LFC submits, once it is accepted that as a matter of law, general fire safety measures for classes of residents are capable of amounting to general fire precautions, the question of whether or not the safety measures in the 2015 briefing note and the 2015 FRA amounted to general fire precautions was a question of fact for the Judge to determine, based on all the material before him. He was fully entitled to prefer the evidence of Mr Hazelton over that of Mr Todd and Mrs Jejna.

77. The Judge was then also fully entitled, having read and heard all of the evidence, to make the clear finding that the omission of even maintaining a watch on a smoker resident in Mr Skyers' position while he was smoking "fell all square within the causation of this accident". There is no arguable basis for interference with his rejection of BUPA's submission that the failure to follow up on the manager's briefing note of April 2015 did not play more than a minimal part in Mr Skyers' death.

Ground 2: consent

78. As the Judge stated in his sentencing remarks, he simply could not agree that it was open to BUPA to proceed on the basis that any resident had an entitlement, whether express or implied, to withhold their consent to the provisions and recommendations in the briefing note and the 2015 FRA.
79. Again, we see no arguable basis for appellate interference with this conclusion.
80. As set out above, the 2014 Regulations do not define "care and treatment" as such. However, Regulation 2 provides separate definitions of "personal care" and "treatment". Both are associated with forms of physical, active intervention: acts such as assistance with eating, drinking and washing; or the carrying out of medical screenings and the provision of nursing, personal and palliative care. Such acts necessarily involve direct interference with the person.
81. The language, structure and context of Regulation 11 point away from the very broad definition suggested on behalf of BUPA. The fact that "care" and "treatment" are taken together implies something more nuanced than *all* forms of interaction between resident and carer, particularly given the narrower definitions in Regulation 2.
82. It is also difficult to square BUPA's broad definition of "care" with Regulation 12. Regulation 12(1) describes the need for the provision of care in a "safe way". It is difficult, if not entirely impossible, to see how there is any need to ensure supervision is carried out safely. On the contrary, supervision is the very act ensuring that the care *is* carried out safely; it is one step removed from the care itself. The same can be said of the list in Regulation 12(2) as to what a registered person must do in order to comply with Regulation 12(1). Regulation 12(1)(a), for example, discusses a service user "receiving" care or treatment. Yet supervision is a passive act of non-interference, not something that, under natural language, is "received". Similarly, Regulation 12(1)(b) refers to "mitigat(ing) any such risks" in the provision of care. Supervision, as opposed to the provision of assistance with eating or washing, is not in itself a risky activity.
83. Further, and significantly, there is no mention anywhere in the 2015 briefing note, which directly mandated home managers to instruct colleagues not to leave a resident smoking unsupervised, of any need for consent. Nor was there any reference to a need for consent in the smoking risk assessment drafted by BUPA after Mr Skyers' death.
84. As it did to the Judge, it seems to us entirely counter-intuitive to countenance a requirement for consent in the context of necessary safety precautions. Supervision of resident smokers was a matter pertaining to the manner in which care homes are run in order to keep residents safe. It was not about the provision of care or treatment requiring consent. Put another way, BUPA could not allow its residents to smoke unsafely. If

residents could only smoke safely with supervision, then proper supervision had to be put in place. As Ms Naqshbandi put it, lack of consent cannot trump safety.

85. The expert evidence was consistent with this approach. Mrs Jejna’s evidence was that she had never come across a situation where a resident had refused supervision of smoking. But if it was unsafe for a resident to smoke unsupervised, and supervision was refused, it would be for the care home management team to take further steps to deal with the situation. It might be that the person could be asked to move to another care home. It was not a situation where the resident’s wishes came before safety. Similarly, Mr Hazelton confirmed his view that supervision was key and ultimately the most effective solution to allow persons prescribed paraffin-based products to smoke safely. The alternative would be to prohibit them from smoking altogether.
86. Further, and again for the sake of completeness, we record that we do not consider that there is material assistance to be gained from the 2019 Guidance. It post-dates the events in question, but more importantly addresses the quite different context of mental health inpatient services. Nor does the counterfactual posed by BUPA advance its cause. The suggestion is that, if supervision is not “care and treatment” for the purpose of Regulation 11, then there would be no requirement for a competent person to provide it, rendering the notion of supervision meaningless. We do not accept that this necessarily follows at all: the notion of supervision imports the involvement of someone who is competent to supervise.
87. For all these reasons, the Judge’s approach to the need for consent in Regulation 11 was entirely legitimate.
88. Finally, there is the added complication on the facts that Mr Skyers was in any event never asked to give his consent to supervision for safety reasons, let alone did he refuse to give it. The Judge made no (and was not asked to make any) findings in this regard. But if BUPA was obliged under the FSO to supervise Mr Skyers whilst outside smoking, and there was an obligation to gain his consent for such supervision, then there was another failure on the part of BUPA in failing to seek it or, taking it into the realm of the general, rather than the person-specific, a failure to put in place arrangements for the obtaining of consent from residents.

Ground 3

89. We can deal with Ground 3 shortly. It is unarguable. The Judge plainly considered the position of BUPA in its wider context, as a broad corporate entity and considered the measures in place across its care home estate. Thus, by way of example, he recorded in terms the prosecution submission that:

“I should remind myself that it is the defendant corporate entity that is being prosecuted, not the premises and its managers, so I should have regard to the efforts that the defendant made to address risk with a view to ensuring that there would be arrangements in place to address the management of fire safety.”

90. He summarised the structure and management of BUPA’s fire safety arrangements, from developing policy and guidance documents, to circulation of those documents, to reviews of its care homes. He noted failings which persisted throughout BUPA’s

organisation. Thus, for example, he referred to the general omission in BFM 20 of any reference to the dangers arising from the use of paraffin-based products. He noted the failure to follow through on targets, such as fire safety training of the Home's manager. The key general failures were, so the Judge was entitled to find, a failure to understand adequately the risks arising out of the use of emollient creams and a failure to think through the risks of fire outside buildings.

91. The Judge was fully entitled in this context to rely on the three warnings in 2015:
- i) The 2015 briefing note: by this stage there was a recognised industry-wide concern about risks from paraffin-based products. The note acknowledged prior related incidents, including one previous fatality in a care home;
 - ii) The 2015 LFB letter: the London Fire Brigade wrote to BUPA reminding it of the risk from fire in all of its care homes and identifying the fire risks for smokers and those with limited cognitive ability or mobility. The particular dangers where residents were known smokers were emphasised. Appropriate control measures and additional equipment to best manage the risk of fire and support individuals at greater risk needed to be identified. The first suggested measure was "Supervision of smoking";
 - iii) The 2015 FRA identified risk from paraffin-based products and required a number of steps to be taken in response.
92. The warnings issued by BUPA were just as relevant as the warning issued to it. As a corporate entity, BUPA was responsible for ensuring that its policies were not only created but implemented in each of its care homes following its "belated identification" of the problem. There was also evidence from the Home's manager to the effect that multiple residents used paraffin-based products and multiple residents with significant vulnerabilities were allowed to smoke alone unsupervised for half an hour or more.
93. There is, in summary, no proper basis for interfering with the Judge's careful assessment of culpability, after reading and hearing a very substantial amount of lay and expert evidence.

Conclusion

94. As has been stated by this court on many occasions (see for example *Butt* at [23]; *R v New Look Retailers Ltd* [2010] EWCA 1268 at [42]), serious breaches of fire safety regulations are met with severe penalties. Fire is an especially potent hazard; the nature of the risk against which protection is required is risk of death or serious injury in a fire. The court does not have to wait until death or serious injury occurs to mark breaches of a defendant's duties under the FSO. Tragically, in this case, death did occur.
95. For the reasons set out above, like the Single Judge, we conclude that the fine of £937,500 was not arguably manifestly excessive. We refuse the renewed application for leave to appeal sentence.