

IN THE HIGH COURT OF JUSTICIARY

The Hon. Lord Brodie

HER MAJESTY'S ADVOCATE

against

ICL Tech Ltd. and ICL Plastics Ltd.

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**PLEA IN MITIGATION OF SENTENCE**

**INTRODUCTION**

1. This plea is structured as follows:-

- i. The history of the companies;
- ii. The causes of the accident;
- iii. Co-operation given to the authorities by the companies following the accident;
- iv. The companies' dealings after the accident with the families of the deceased and with those injured;
- v. Culpability;
- vi. The companies' ability to pay a fine;
- vii. Concluding summary.

## THE HISTORY OF THE COMPANIES

2. ICL Plastics Ltd., the second accused company, was formed by C. H. Downie and R. Cunningham in November 1961. Mr Cunningham was production director and Mr Downie was sales and finance director. Mr Downie, who is now aged 72, is currently chairman and a director of ICL Tech Ltd., the first accused company. He is now, as he was in May 2004, semi-retired. Mr Cunningham resigned as a director in February 1966. Between 1961 and 1965, ICL Plastics Ltd. pursued experimental work, perfecting a new technology based on polymer particle fluidisation, which was a method of applying industrial coatings and linings, hence the acronym ICL.
3. Between 1965 and 1969, this small business expanded into new areas of the polymer industry. Between 1970 and 1973, product diversification took place with operating divisions being formed within ICL Plastics Ltd. Thereafter, between 1973 and 1975, a more formal company structure was proposed, with autonomous subsidiary companies being formed. These were the first accused company, then named ICL Technical Plastics Ltd., (responsible for manufacture) and Stockline Plastics Ltd. (with distribution responsibilities). ICL Plastics Ltd. became a holding company, with Mr Downie as chairman.
4. Throughout the 1980s and 1990s, ICL Technical Plastics Ltd. (renamed ICL Tech Ltd., for brevity, in 1999) expanded into new areas of work and specialised in state of the art production equipment. During the period from 1973 to 1990, ICL Tech Ltd. was the first in Scotland's plastic industry to achieve the quality control certification, British Standards Institute 5750 (now ISO 9001). The company holds a number of customer approved supplier certifications, including one from British Aerospace, the grant and renewal of which requires repeated rigorous internal inspections of the factory and the process. From around five employees in the 1970s, ICL Tech Ltd.'s workforce grew to about thirty employees in the 1980s.

5. After ICL Plastics Ltd. was established as a holding company in the 1970s, it became responsible for maintaining the group's financial resources, providing accounting services, carrying out strategic market analysis and undertaking research and development. There are presently six subsidiaries, Plastics W. Graham Ltd., Easter Road Plastics Ltd., Brisbay Ltd., Norplast Ltd., ICL Tech Ltd. and Stockline Plastics Ltd. More is said about the interaction of these companies among themselves in the section which addresses the issue of the ability of the accused companies to pay a penalty.
6. In their forty-five year history, neither ICL Plastics Ltd. nor any of its subsidiary companies has been convicted of any health and safety or other offence.
7. In the tragedy, the companies lost their records, and their communications network and other essential equipment. The greatest loss to them, however, was of those who perished. They are considered irreplaceable and are much missed by their work colleagues. Those who survived and who continue to be employed by the ICL group are endeavouring to succeed in difficult circumstances.
8. ICL Tech Ltd. is continuing to operate from temporary premises in Maryhill. However, redevelopment is scheduled and ICL Tech Ltd. is faced with a costly move to a new location. The replacement of all of its operating resources, including IT networks, telephone systems, process equipment and special purpose machinery has been carried out progressively since the accident.

## **THE CAUSES OF THE ACCIDENT**

9. In order to gain a full understanding of the causes of the accident, it is necessary to know something about the history of the pipe that failed.

*The history of the pipe – essential causes of the accident*

10. As the court has heard, the pipe was installed in 1969. At that time, there was no Health and Safety at Work Act and there were no statutory requirements for risk assessments to be made. No gas supplier or consumer had in place any systematic programme of replacement of either gas mains or services. The then current scientific understanding of gas explosions would now be regarded as primitive. It was only after the occurrence of the Flixborough disaster, in 1974, that a great deal of research in the area of gas explosions took place.
11. The gas pipe which failed in this case was made of corrodible carbon steel. Some parts of it were protected by galvanising, but there was no such protection at the point of failure, which was at a cut thread. The cut thread should have been wrapped for protection from corrosion, but it was not. The responsibility for the installation of the pipe work was given to an independent contractor who specialised in the relevant area of work. A second independent specialist contractor was engaged by ICL Plastics Ltd. to supervise the work.
12. ICL Plastics Ltd. instructed what they believed were competent contractors both to carry out and to supervise the work of installing the pipe, from bulk storage tanks across the yard and into the building. The failure to protect the pipe in 1969 contributed to the occurrence of the explosion, in that it made it more likely that the pipe would corrode, fail and leak. Such leakage was the first of three essential causes of the accident.
13. Further, during installation, the pipe should have been sealed to the brickwork at the point at which it entered the building, but it was not. The failure by the independent contractors to seal the pipe at the time of installation, and the failure by the independent supervising company to notice the absence of a seal at the time of installation was the second of the three essential causes.

14. For as long as the point of entry was above ground on the outside of the building, however, lack of sealing could not have caused the explosion, because any gas escaping from an external leak would disperse in the air rather than migrate into the building. In 1974, however, ICL Plastics Ltd. caused the level of the yard to be raised by about three feet four inches. Consequently, the section of pipe, which originally rose above the surface of the yard and into the building, was buried beneath an impermeable concrete surface. Once that had been done, gas escaping from the pipe could migrate into the building through the unsealed penetration, mix with air, and accumulate into an explosive mixture, as it did on 11 May 2004. The raising of the yard was the third of the three essential causes.
15. Having regard to the history of the pipe up to 1974, therefore, the court will see that all of the essential causes of the disaster were in place some thirty years before the accident occurred.
16. The failings that gave rise to these causes should be seen in the context of the state of knowledge within the gas industry, between 1969 and 1974, of the nature and extent of risks created by gas leaks. That state of knowledge can be gauged from the circumstances of the 1977 King Report. Following a series of gas explosions in the winter of 1976-77, a government inquiry was set up under the chairmanship of Dr P. J. King to examine their circumstances, and to make recommendations with a view to reducing the severity of such incidents in future. One such recommendation was that British Gas should replace all “high risk priority” mains, i.e. those located in areas of high risk, by 1984. That recommendation, however, did not apply to pipes categorised as “services”, into which category the pipe which failed in this case fell. Gas escapes from services were found to cause fewer explosions than those from other parts of the gas distribution system. It was also found that about half of the escapes from services which led to explosions were caused by direct interference (digging, etc.) rather than defects in the services. Further, experience showed that most gas leaks caused by corrosion are detected by smell and dealt with before any serious consequences occur. The smell of gas was and continues to be regarded as “an

important, indeed essential, safeguard”. “The characteristic odour of gas is still the best safety device for giving notice of leaks.” [King Report, pages 17 and 2]

*The history of the pipe –causes contributing to the accident*

17. In 1980, ICL Plastics Ltd. caused a steel floor to be installed over the basement area where the LPG pipe work ran. What had been a ventilated space thus became unventilated. Design codes from 1981 advise that a gas service should not be installed in an unventilated space. At the time when the steel floor was installed, however, it appears that there was no such requirement. When gas migrated into the space through the unsealed wall penetration, the lack of ventilation is likely to have allowed an explosive mix of air and gas to build up more rapidly than if the space had been ventilated. Further, when the gas ignited, the immediate destruction of the steel floor which occurred is likely to have contributed to the violence of the explosion.

*The history of the pipe – missed opportunities to avoid the accident*

18. An opportunity to discover the state of the pipe and so avoid the accident was missed in 1989. The Health and Safety Executive’s inspection file for the factory shows that, on 9 August 1988, HSE inspected the premises, paying particular attention to the LPG installation. [CP 221, page 29] HM Principal Inspector of Factories, J.K. Ives, wrote to ICL Technical Plastics Ltd. on 8 September 1988, with twelve recommendations. [CP 221, pages 46-48] Most of the recommendations addressed the LPG storage tank and concerned siting issues (such as the risk of vehicle collision and activities on uncontrolled adjoining land), the risk of conventional fire among articles stored near the LPG tank, limitation of the LPG inventory, and fire fighting equipment.

19. The service pipe was addressed in only one of the twelve recommendations. Recommendation 11 of Mr. Ives’s letter advised that: “*Part of the underground pipework carrying LPG vapour into the building should be excavated. The state of the pipework and any corrosion protective coating should be examined by a*

*competent person and any recommendations made as a result of this inspection should be carried out. A pressure test of the pipework should also be carried out."*

20. ICL appear to have copied HSE's letter to its LPG supplier, Calor Group plc, whose Senior Group Safety Inspector (Scotland), Mr Coville, wrote to Mr. Ives on 4 January 1989, addressing the recommendations about the LPG tank and its surroundings. [CP221 page 81] In this letter, he proposed to take the opportunity to assess the condition of the service pipe in the following way: *"The condition of the attendant vapour off-take pipe would be ascertained, during vessel exchange, by examination of the 'riser pipe', at the vessel, and by a pressure test on the pipeline"*.
21. It is submitted that it was right that ICL referred HSE's recommendations to their supplier Calor, because these issues were more within the latter's expertise. On 18 January 1989, Dr. Alan Tyldesley of HSE (the inspector whose report formed the basis of Mr. Ives's recommendations) wrote to ICL regarding Calor's proposals, and said: *"In respect of recommendation 11 regarding examination of the underground pipework from the installation, then the proposals by Mr Coville are acceptable."*
22. At that time, and subsequently, it was considered that a pressure drop test was the appropriate proof test for newly installed service pipes and the consumer's installation. [CP323 Section 6.2.1 and CP317 paragraph 6.3.2]. In such a test, a pressure indicator is attached to the tank or pipework and the pressure is elevated to about 50% or 100% over the normal operating pressure, with all the appliances shut off. The pressure is held for some 15 minutes while the observer watches for any reduction in the pressure indication. The test is similar to that conducted on natural gas consumer installations, and can be applied to buried or above-ground pipework. The test is very sensitive to any leakage, and was recommended in the relevant Codes of Practice from at least 1986 to 2000, for installations operating

at 5 bar or above. The service pipe which failed was operating at a lower pressure, 1.4 bar.

23. The documentation in this case indicates that a pressure drop test was carried out on that pipe on at least two occasions after 1989. The first was in late 1998. That was done by crown witness 167, David Inglis, a CORGI registered gas fitter, during the installation of a replacement LPG tank at ICL's premises. He describes his pressure test in three statements given to the crown. Although he has carried out so many tank installations that he could not remember this specific one, his evidence indicates that nothing untoward was found. It seems certain, therefore, that the service pipe would have passed any pressure drop test conducted prior to that date.
24. A further pressure drop test was carried out in 2002, by the same witness, when again no loss of pipe integrity was revealed.
25. The last occasion on which the condition of the service pipe might have been discovered was when it failed. An odorant is added to LPG so that, in the event of a leak, it may be detected before an explosive mix of gas and air can accumulate. The odorant is regarded in the gas industry as the first line of defence against explosions. The fact that no one reported a smell of gas in the area before this explosion suggests that the onset of the leakage of a quantity of gas sufficient to fuel this explosion was rapid. Had the leak been gradual, as is usual where loss of pipe integrity is caused by corrosion, it may well have been detected by smell and the explosion avoided.

#### *ICL's Risk Assessment*

26. ICL Tech Ltd. regularly carried out company-wide health and safety management reviews. Safety manuals, rulebooks and training and competence records were all destroyed in the accident. The person responsible at the plant for making and implementing risk assessments and their implementation was a director of both

ICL Plastics Ltd. and ICL Tech Ltd. Regrettably, that person died in the explosion.

27. It is accepted by the nature of these pleas of guilty, however, that the companies' risk assessment was deficient in certain respects, and that is the area which is dealt with now.
28. The advice given to the companies by an eminent health and safety expert, Dr Tony Cox, in the course of preparing for this case, is that risk assessments can identify hazards and can lead to the adoption of safeguards that reduce risks but, because they are made without the benefit of hindsight, they cannot guarantee that every hazard has been identified nor that the related safeguards will eliminate all possible risks.
29. The duty of each of the companies was to make "a suitable and sufficient assessment of the risks to the health and safety of [their] employees to which they are exposed whilst they are at work; and the risks to the health and safety of persons not in [their] employment arising out of or in connection with the conduct by [them] of [their] undertaking, for the purpose of identifying the measures [they] need to take to comply with the requirements and prohibitions imposed upon [them] by or under the relevant statutory provisions." The companies were required, therefore, to apply their mind to the entire risk profile created by every aspect of their undertaking.
30. The principal risk assessment to be found amongst the documentation in this case is entitled "ICL Tech Ltd., Health and Safety Programme - Risk Assessment". This document, which is undated, contains 32 pages of tabulated risk assessment for work-related activities. The work activities covered are:-

- i. Degreasing
- ii. Shot and bead blasting
- iii. Powder coating dip process

- iv. Powder coating electrostatic
- v. Wet spray coating
- vi. Gas appliances
- vii. Compressed Air Systems
- viii. Electrical appliances
- ix. Fork lift operation
- x. General Lifting
- xi. Access and egress
- xii. General Maintenance
- xiii. Cementing
- xiv. Plastic welding
- xv. General saw work
- xvi. Vacuum Forming
- xvii. CNC Machining
- xviii. Routing
- xix. Use of electric hand tools
- xx. Chemical storage
- xxi. Use of office equipment
- xxii. Flame polisher
- xxiii. General movement in factory

31. This lengthy list shows that ICL Tech Ltd. were attempting to identify and include all of their work activities in their risk assessment. A great number of these presented known occupational risks which may be expected to occupy the mind of safety managers in this type of work environment, because they dominate the toll of work-related injuries and ill-health. The obvious examples are exposure to chemicals and vapour, cuts and crushing from power equipment and tools, and slips, trips and falls. This, it is respectfully submitted, is the context in which the failure to identify the risk of explosion caused by a leak from the exterior pipe should be viewed. The gas inside the factory was identified as a hazard, but the possibility of a leak of gas from the exterior pipe was not.

32. So far as a risk assessment was concerned, ICL Plastics Ltd. was in a different position from ICL Tech Ltd. As the operator of the processes carried on in the premises, ICL Tech Ltd. took on the task of making a risk assessment in respect of these activities. ICL Plastics Ltd. owned the premises, including the yard through which the LPG pipe ran. Its duty to carry out a suitable and sufficient risk assessment lay in a different context, and it is understandable, perhaps, that the making of a risk assessment was left to the operating company, particularly given the common directorship.
33. For all these reasons, it may be understood why the potential hazard posed by the exterior service pipe was not recognised as a risk which required to be addressed.
34. In summary, this tragedy happened because of a combination of essential causes and missed opportunities to prevent it:-
- i. The pipe corroded and finally leaked at a point where it was not properly protected from corrosion as it should have been. The responsibility for that lay with persons other than the ICL companies;
  - ii. The leak did not escape to atmosphere. This was made certain by the concreting of the yard when it was raised in 1974. At that stage, however, it appears that no one realised that the pipe entering the building had not been sealed;
  - iii. The pipe was not sealed to the brickwork at the point of entry to the building when it was installed. That provided escaping gas with a route to the interior of the building where it could accumulate, mix with air, and ignite. Again, responsibility lay with persons other than the ICL companies;
  - iv. The ICL companies did not identify the possibility of a leak of gas from the service pipe outside the building as a risk that required to be addressed by a suitable and sufficient risk assessment;

- v. The leakage was of sudden onset. Had the leakage developed gradually as usually happens where there is a corrosion failure, it is likely that the gas would have been detected by smell before an explosive mixture of gas and air accumulated.
35. For reasons given more fully below, it is submitted that the ICL companies' part in that sequence was attributable to inadvertence rather than anything more blameworthy. Had advice been given to ICL to excavate the pipe at any time over the last thirty-five years, whether from within or outwith the company, then that would have been done without hesitation and the accident would not have happened.

#### **FOLLOWING THE ACCIDENT**

36. All enquiries by the police and the Health and Safety Executive were dealt with by the companies in a spirit of full co-operation. When a decision was taken to prosecute ICL Tech Ltd. and ICL Plastics Ltd., there were discussions with the crown with a view to agreeing as much evidence as possible to minimise the length of any trial. The companies were particularly anxious that no employee who was injured or family of anyone who died should be caused unnecessary suffering by being called to give evidence and, accordingly, every medical record and all subsequent medical records over the years were agreed by joint minute.
37. As the issues between the parties in terms of very significant amounts of evidence became narrower, another joint minute of substance was entered into, agreeing the nature of the explosion and how it came about. Discussions continued and, in due course, a trial, which the crown had estimated would last in excess of three months, was set down for a period of about twelve days. In forming the initial intention to go to trial, there was no question of the companies shirking responsibility for what had occurred. There was expert evidence available to them on serious issues of causation which appeared to conflict with the crown's

position. As soon as certain matters were clarified, the companies took the decision to tender pleas of guilty.

38. In summary, the companies have co-operated fully at all times in the conduct of the investigation and the prosecution.

### **DEALING WITH THE FAMILIES OF THE DECEASED AND WITH THOSE INJURED, AFTER THE ACCIDENT**

39. As has been already said, nine people died and forty-five people were injured or otherwise affected because of the events on 11 May 2004. The tragedy of that day has affected everybody involved, both in the companies and in the local community. One of the immediate concerns of the directors of the companies was to pay the full cost of the funeral expenses incurred by the bereaved, in order to avoid hardship. A trust, the Hopehill Trust, was set up on the initiative of Mr Downie. The companies asked two former directors to become trustees. £2,000 was donated by Mr Ferguson, one of the shareholders, and ICL Plastics Ltd. contributed £25,000. Its purpose was to alleviate the financial burden of funeral expenses.

40. On 12 May 2004, Proclaim Care were instructed to provide rehabilitation, counselling and other services, to support the immediate needs of employees, relatives and rescuers. As at 14 May 2004 facilities for accessing Proclaim were in place and a dedicated helpline was set up. The helpline was manned by ICL personnel. To date, at least twenty-six persons have engaged the services of Proclaim and this has involved rehabilitative therapy, such as physiotherapy, nursing care, and assistance with purchase of adaptations necessary to support the needs of injured persons. Proclaim continue to be involved to this day.

41. Before business reconstruction could be considered the directors were concerned about the employee's wages. The companies were able to maintain full basic wages through to August 2004, and thereafter they have continued to pay full

salary to those severely injured and not working. They continue to pay a proportion of basic wages to others less severely injured and not working, to add to the incapacity benefit they now receive. In total, since 11 May 2004, payments made by the companies to those employees unable to return to work amount to just under £700,000.

42. In addition, in late May 2004, claims started to be intimated by solicitors instructed on behalf of employees, their relatives and other persons injured as a consequence of the accident. To date, eight of the claims have been settled and for the remainder of the claims, court actions have been raised and are presently sisted. Solicitors for the companies, HBM Sayers, continue to negotiate with the various claimants solicitors and since the accident, insurers have paid out a total of £293,000 in respect of hardship and interim payments.
43. The companies, working together with the families and with Glasgow designer Patrick Moran, created a memorial garden as a permanent tribute to those who lost their lives. The creation of the memorial garden was funded by the companies. . This approach, by the owners of this comparatively small business, demonstrates how seriously they take their responsibilities to their employees, many of whom they have known as friends over the years.
44. There are currently eighty-two employees on the group companies' books, of whom nineteen are still off work. Since the accident, everyone within the workforce, including a number of those who were injured in the blast, has worked heroically to help revive the fortunes of the business. There are numerous examples of such people but, among them, is an employee who, despite having suffered amputation and being wheelchair-bound, has returned to his job of running quality assurance. Purchasing and transportation needs are in the charge of an employee who is back at work after suffering severe back injuries, and the office administrator has returned, notwithstanding severe head injuries. In all, eleven of the injured are back at work. The future of the business is dependent on

such people, and, of course, they are all dependent on the successful future of the business.

## **CULPABILITY**

45. The disposal of this case will reflect the degree of culpability shown by each company. Culpability in the contravention of a statute ranges from, at the highest, a wilful disregard of the statute, to a reckless disregard, and down through carelessness to a non-negligent, or inadvertent breach. I invite your Lordship to treat the charges before the court today as falling well towards, or into, the lowest of these categories. This is not a case of the type, for example, in which dangers were deliberately courted or obvious risks were taken for the sake of profit and which, rightly, attracts very severe penalties.

46. In its narrative, the crown makes this assertion:-

*“... .. in addressing the question of culpability the Court may wish to know whether if risk assessments had been carried out the tragedy could have been prevented.”*[Page 36]

47. Two comments fall to be made in response to that assertion. The first is that culpability, or blameworthiness, is determined by having regard to the whole circumstances of the commission of the offence, including the state of mind of the offender. Blameworthiness is not, it is submitted, determined by the severity of the consequences of the commission of the offence.

48. The second thing to be said is that, by tendering these pleas, the companies accept that the explosion **could** have been avoided. That is not to say, however, as the crown seems to suggest, that the accident necessarily **would** have been avoided. As the Report on Industry Guidance to the Procurator Fiscal rightly says, “*The*

*inspection and maintenance prescribed for underground pipework operating below 5 bar was ambiguous and ineffectual, eventually permitting the use of only a pressure test to determine the integrity of the underground installation with no other requirement to excavate and examine the condition of the pipe or the corrosion protection.*” [CP 460] There was, in fact, no requirement in the guidance “to excavate and examine the condition of the pipe or the corrosion protection”, and the crown points to none.

49. The crown concludes its argument on culpability by expressing its view that “*by far the likeliest course to have been followed by the First and Second Accused Companies had they applied their minds to the issue at all, would have been to consult their suppliers and not to try and find the industry guidance and then interpret for themselves.*” In fact, as has already been shown, the companies did consult their suppliers in late 1988. It was the suppliers who advised that the Health and Safety Executive’s recommendation, which would have required excavation and examination of the pipe if it were to be implemented, should not be followed.

#### **THE COMPANIES’ ABILITY TO PAY A FINE**

50. The court and the crown have been provided with copies of the relevant accounts.

51. Your Lordship has heard that the group comprises seven companies. All of the companies in the group are interconnected. There are, for example, inter-company balances, inter-company trading, skill sharing, etc., and it is necessary, therefore, to consider the position of all of the companies together in order fully to understand their finances.

52. The group has achieved slow but steady growth over the years without the aid of bank funding. The group’s policy over some thirty-five years has been to build up and retain a financial cushion for periods of poor trading and to support

financially weaker companies in their development phase, in order to sustain employment without redundancies. In addition, research and development takes place without recourse to grants, and investment in state of the art equipment takes place without recourse to leasing. The profits generated by the business are retained by the companies to facilitate capital expenditure requirements. No dividend has ever been paid to shareholders.. In addition, the chairman has loaned the company funds from his personal resources to assist with financing. Consequently, the bank balances and accumulated reserves shown in the accounts are the result of thirty-five years trading and retention of reserves, with the addition of insurance moneys paid following the accident.

53. The current position is that Easter Road Plastics Ltd., Norplast Ltd., and Stockline Plastics Ltd., which are all distribution companies, have no borrowings. There is a deficit in Brisbay Ltd., a manufacturing company, which is funded by the ICL group. P. W. Graham Ltd. and ICL Tech Ltd, which are both manufacturing companies, have a surplus, which is used by the holding company ICL Plastics Ltd. to finance its subsidiaries.
54. Your Lordship will see that defence production 2 contains figures for the last three years showing the audited results from the profit and loss account of both ICL Plastics Ltd. and ICL Tech Ltd. Your Lordship will see, also, that ICL Plastics Ltd. made a loss over the three year period, and that ICL Tech Ltd. made a profit over the same period.
55. Further, to assist the court in determining the amount of the appropriate penalty, under the heading “Current Cash Position”, your Lordship will see details of the funds currently available to the group. The amounts required by the other companies in the group to continue to operate to trade at the same level are given. Your Lordship will appreciate that a consequence of a reduction in these reserve funds will be to reduce investment opportunities internally and to reduce capital expenditure.

56. As a result of the operation of the principle that the strong companies support the weak, the group has had few redundancies in its forty-five year history, perhaps up to ten in the years to 2004 and four voluntary redundancies in the last three years. It is respectfully submitted that the amount of any fine should not only reflect the mitigation advanced but should also be set at a level that will allow the group to continue to trade and to provide employment for its whole workforce. Many who were injured still rely on these companies to provide for them and their family. It would only add to the tragedy if, as a result of these guilty pleas, further hardship were inflicted on the survivors and their work colleagues.

### **CONCLUDING SUMMARY**

57. Everyone involved in these two ICL companies feels profound sadness and regret that what happened on 11 May 2004 has blighted so many lives. They realise that the court must impose a financial penalty, but they ask that the level of that penalty should reflect the following principal factors:-

- i. In their forty-five year history, no member of the ICL group of companies has ever before been convicted of any offence;
- ii. The accident was caused by a combination of apparently unrelated circumstances, coming together over a period of thirty-five years;
- iii. The one measure that would have avoided this accident, excavation and/or abandonment of the service pipe, is not the subject of express guidance in any relevant Code of Practice or guidance. It was recommended and then departed from by the Health and Safety Executive. Calor, the specialists in the field, gave contrary advice, which was accepted by both HSE and, quite understandably, by the ICL companies;
- iv. The companies' failings were due to inadvertence, rather than any deliberate, reckless or even negligent disregard of their statutory duties;

- v. Consistent with that, the companies have shown deep remorse and a continuing commitment to the welfare of all of those affected by the tragedy; and
  - vi. The workforce, including many of the injured, rely on the continuation of the business for their livelihood.
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IN THE HIGH COURT OF JUSTICIARY

The Hon. Lord Brodie

HER MAJESTY'S ADVOCATE

against

ICL Tech Ltd. and ICL Plastics Ltd.

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HBM Sayers