COMHAIRLE NAN EILEAN SIAR 1 OCTOBER 2025

PROSECUTION BY THE HEALTH AND SAFETY EXECUTIVE

Report by the Monitoring Officer

PURPOSE

1.1 The purpose of the Report is to inform the Comhairle of a breach of health and safety legislation, the subsequent prosecution of the Comhairle and the remedial steps that have been taken.

EXECUTIVE SUMMARY

2.1 In the early hours of 9 March 2024, an individual absconded from St Brendan's Care Home, Isle of Barra. Staff alerted the emergency services, and the individual was found and was taken to hospital but unfortunately passed away.

2.2 Prior to the incident, the Service had identified actions that were required in order to improve the security of its care homes. St Brendan's was included in those actions, and the commissioning of maglock external doors had commenced. Unfortunately, the work had not been completed on site at the time of the incident.

2.3 In accordance with its legal obligation, the Comhairle promptly informed the Health and Safety Executive which proceeded to conduct an investigation. That resulted in a prosecution for alleged breaches of the Health and Safety at Work etc. Act 1974. In accordance with external legal advice, the Comhairle pled guilty to the charge.

2.4 The case called in Lochmaddy Sheriff Court on 6 August 2025. Counsel for the Comhairle submitted a detailed plea in mitigation setting out, amongst other things, the remedial action that had been taken, both before and after the incident, in order to minimise the risk of such incidents recurring. The Comhairle was fined £80,000 with a victim surcharge of £6,000.

2.5 Since the incident, all but one of the outstanding remedial actions, both those required by the Health and Safety Executive and those identified by the Service itself, have been undertaken. The remaining action, relating to car park lining, is partially complete but had no bearing on the incident or the prosecution.

RECOMMENDATIONS

3.1 It is recommended that the Comhairle notes the Report.

Contact Officer:	Tim Langley, Monitoring Officer
Appendix:	None
Background Papers:	None

IMPLICATIONS

4.1 The following implications are applicable in terms of the Report.

Resource Implications	**Implications/None**
Financial	The Comhairle is required by the Court to pay £86,000.
Legal	None
Staffing	None
Assets and Property	None
Strategic Implications	**Implications/None**
Risk	None; the risks that gave rise to the incident have been addressed
Equalities/Child Rights	None
Corporate Strategy	Deliver community leadership – ensure effective governance of the Comhairle
Environmental Impact	None
Consultation	None required

BACKGROUND

5.1 St Brendan's Care Home on the Isle of Barra is owned and operated by the Comhairle, providing ten residential care beds.

5.2 Residents in care homes are supported to maximise their independence and maintain their social connections in keeping with their individual needs and preferences. This results in an obligation on the Comhairle as the care provider to ensure that the specific care needs of every individual resident are met. That means that appropriate measures need to be put in place so as to protect particularly vulnerable residents from leaving the care home premises unaccompanied. The Residential Services team is continuously alert to those needs, and takes action to address the necessary security arrangements whilst respecting the need to maintain a homely environment.

5.3 Section 3(1) of the Health and Safety at Work etc. Act 1974 ("the Act") states:
It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonable practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.
For the purposes of the subject-matter of this Report, "persons not in his employment" means the residents of care homes.

5.4 Risks can never be entirely eliminated. The point of s3(1) of the Act is that the Comhairle is under a duty to take reasonably practicable steps to look after the health and safety of residents.

5.5 The Service had identified actions that were required to be taken in order to address the risk of residents walking with purpose whilst unaccompanied, and began work to improve security measures in its care homes. In the case of St Brendan's, one of those was the installation of maglocks: magnetic locks which could be released automatically in the case of an emergency. Planning for those works started towards the end of 2023. In January 2024, approval for the works was granted, and they were scheduled to be started on 25 March 2024.

THE INCIDENT

6.1 The risk assessment process undertaken by the Service includes consideration of the risk associated with individuals who may walk with purpose whilst unaccompanied. Mitigating actions to reduce that

risk include the use of a "wander guard" bracelet. This appliance will trigger an alarm if the individual wearing it moves out of certain areas. One of the residents who had walked with purpose unaccompanied had such a bracelet but did not routinely tolerate wearing it at night. However, because that resident's patterns of behaviour were observed to be stable at night, other mitigatory measures were in place instead which were considered adequate; they included hourly checks throughout the night.

6.2 On the night of 8-9 March 2024, the resident in question was supported to bed and settled. At midnight and at 1am they were checked and found to be soundly asleep. At 2am, however, they were found to have left the bedroom. Staff immediately carried out a search of the building and then alerted the Police, who alerted other emergency services. At about 6am, the resident was found a few hundred yards away and was taken to hospital but passed away shortly after admission. The postmortem indicated that the resident had died of exposure and hypothermia.

6.3 The Comhairle promptly reported the incident to the Health and Safety Executive ("HSE"). HSE subsequently carried out a formal investigation of health and safety compliance at the Care Home. That included attendance at the Care Home, and interviews with staff, on 15 and 16 April 2024. As part of that visit, HSE also carried out what they refer to as an "Inspection Following Investigation", which is a routine part of an investigation.

6.4 The principal finding in the investigation and inspection was that, at the time of the incident, there were inadequate control measures in place to prevent the resident in question from leaving the premises unaccompanied. On that basis, HSE found that the Comhairle was apparently in breach of section 3(1) of the Act. However, it should be noted that HSE were satisfied that, since the incident, the Comhairle had completed the appropriate remedial work in respect of the external doors (i.e. the planned installation of maglocks), and therefore that no further action was required in that regard.

6.5 As part of their general inspection, HSE also noted a couple of other issues: windows did not have catches on them to restrict their opening, the result being that they posed an exit risk; and the car park did not have adequate markings so as to protect pedestrians. Neither of these were related to the incident, and apparently had no bearing on the subsequent prosecution.

6.6 Since the incident, the Comhairle took further measures across the Service as a matter of urgency: it reviewed all residents' risk assessments (particularly in respect of walking unaccompanied) and enhanced nightly checks where appropriate, and it fitted window restrictors at St Brendan's.

6.7 As a result of its finding on the first point of the investigation, though, HSE proceeded with a prosecution.

THE PROSECUTION

7.1 In July 2024, the Comhairle received correspondence from the Crown Office and Procurator Fiscal Service ("COPFS") relating to the proposed prosecution. Given the seriousness of the matter and the likely scale of the fine if the Comhairle were to plead or be found guilty, specialist external legal advice was sought. The external legal advisors engaged with COPFS on the Comhairle's behalf, although for several months there was little action taken by COPFS in respect of the proposed case. It also took a long time for the Comhairle's advisors to be provided with disclosure of the evidence from COPFS and to receive formal confirmation of the postmortem findings.

7.2 A draft charge was presented by COPFS in terms of a breach of section 3(1) of the Act, in that the Comhairle:

did fail to provide a safe system of work for ensuring that all external doors were alarmed and that if any resident attempted to exit without the knowledge or consent of employees, there would be a means of alerting said employees thereto.

7.3 Counsel subsequently advised on the Comhairle's position. His view was that the Comhairle should plead guilty. That was essentially for two reasons.

7.4 First, the Comhairle had identified that maglocks were required at the Care Home but they had not been installed by the time of the incident. This was, of course, to some extent a matter of unfortunate timing, as the maglocks had been scheduled to be installed towards the end of March. However, whilst that was a relevant point in mitigation, it was not sufficient to found a defence to the charge.

7.5 Second, given the resident's medical history and tendency to walk unaccompanied, the actions taken to address the risk that those factors posed to the resident were inadequate. That was particularly the case in respect of the use of the wander guard bracelet and the measures that were in place at night.

7.6 COPFS was keen to receive an early indication of what the Comhairle's plea would be. The advantage of a guilty plea would be a reduced fine, and the earlier such a plea were tendered then the greater the likely reduction would be. Conversely, if the Comhairle were to plead not guilty but go on to be found guilty at trial, as Counsel strongly suspected it would, then the fine would be significantly higher. Counsel gave a rough indication of the likelihood of a fine in the region of £100,000 for an early guilty plea.

7.7 Given Counsel's advice as to the strength of its position, the financial and reputational risks to the Comhairle if it were unsuccessfully to plead not guilty had to be taken very seriously. The adverse effect on staff, if they were called to give evidence at trial, was also relevant. With all of those considerations in mind, the decision was made to plead guilty. COPFS was informed accordingly and the indictment was served on the understanding that the Comhairle would formally tender such a plea.

7.8 The case called in Lochmaddy Sheriff Court on 6 August 2025. Counsel duly tendered the guilty plea. The Sheriff was understanding of the Comhairle's position, acknowledging that the Comhairle had co-operated with HSE and COPFS throughout the process, had accepted responsibility and pled guilty at the earliest opportunity, and had taken the appropriate remedial action. He imposed a fine of £80,000 plus a victim surcharge of £6,000 (at the prescribed rate of 7.5% of the fine).

CONCLUSION

8.1 The Comhairle was in breach of its legal duty under s3(1) of the Act in relation to aspects of the service at St Brendan's Care Home. Those breaches resulted in a prosecution in which the Comhairle's best course of action was to plead guilty. It was subsequently fined.

8.2 All remedial actions identified by HSE have been undertaken with the exception of the car park lining; owing to the contractor facing logistical challenges and the weather, that action is partially complete at the time of writing.

8.3 Since the incident, there has only been one case of a resident exiting a Comhairle care home unplanned, but owing to staff vigilance the resident was supported back into the care home without suffering harm. The technical fault that had enabled the incident to happen was immediately addressed.