**Disciplinary Panel Hearing**

**Case of**

**Cushman & Wakefield Debenham Tie Leung Limited**

**London**

**On**

Tuesday 10 & Wednesday 11 January 2023

**Via Microsoft Teams**

**Panel**

Alison Sansome (Lay Chair)
Patrick Bligh-Cheesman
(Lay Member)
Nick Turner (Surveyor Member)

**Legal Assessor**

Ben Kemp

**Firm representative**

Eleanor Sanderson, Counsel, 2 Bedford Row

**RICS Presenting Officer**

Ben Rich, Counsel, 2 Hare Court

**RICS Hearing Officer**

Jae Berry

**The formal charges were:**

1. *On 4 April 2019, the Firm was convicted of the following offence:*

a. *On and before 23 February 2017, the Defendant, being an employer, failed to conduct its undertaking in such a way as to ensure, so far as was reasonably practicable, that persons not in its employment who might be affected thereby, including Tahnie Martin, were not thereby exposed to risks to their health and safety arising in connection with the maintenance of the exterior of the Blackrock Building, including the structures upon it, contrary to Section 3(1) and 33(2)(a) of the Health and Safety at Work etc Act 1974.*

***The Firm may therefore be liable to disciplinary action in accordance with Bye-Law 5.3.2 (a)***

2. *Between April 2011 and 23 February 2017, the Firm failed to act with due skill, care and diligence in that during the course of its appointment as property manager for the Mander Centre, it failed to:*

a. *Identify the structures on the 6th Floor Plant Room Roof of the Blackrock Building ["the Roof"].*

b. *Request that safe arrangements be made to access the Roof so that they could be inspected.*

c. *Inspect the structures on the Roof.*

d. *Repair, and/or recommend maintenance and/or maintain the roof top structures on the Roof*

e. *Appropriately supervise PD in the undertaking of his role as operations manager for the Mander Centre.*

***Contrary to Rule 4 of the Rules of Conduct for Firms 2007***

***The Firm may be liable to disciplinary action in accordance with Bye-Law 5.3.2(c)***

**Background:**

1. The Respondent Firm ("the Firm") has been regulated by RICS since January 2008.

2. Between April 2011 and February 2017, the Firm was the managing agent of the Mander Centre, a commercial development in Wolverhampton, UK, which, from September 2012 included the Blackrock Building.

3. The Firm's duties as managing agent were wide ranging, but for the purposes of this case it was a matter of agreement that they included the following:

a. Identification of the structures and facilities making up the building as necessary for planning and risk assessment purposes.

b. Inspection every 6 months.

c. Raising material defects or want of repairs with the freeholder.

d. Procuring that the property was maintained, repaired and renewed.

e. Arranging works, maintenance or repair to the fabric of the building.

f. Identifying any areas of higher risk on site and ensuring that access was managed appropriately.

4. On 23 February 2017, Miss Tahnie Martin, a young woman aged 29 years old, was walking with a work colleague (Ms RS) in Dudley Street next to the Mander Centre in Wolverhampton. Miss Martin was tragically struck and killed by a large and heavy wooden panel which had been blown off the nearby Roof by heavy winds. Ms RS was also injured by the falling debris.

5. An investigation was commenced into the death of Miss Martin. The investigation concluded at the end of a 5-day jury inquest on 6 October 2017. A report prepared by the Coroner recorded the jury's decision as follows:

*"The large heavy panel which struck Tahnie Lee Martin at 11.38am on 23 February 2017 became detached from the plant room roof of the Blackrock Building due to strong winds caused by 'Storm Doris'. The large heavy panel became detached due to the absence of maintenance which had resulted in wet rot, badly corroded and defective fixtures which had allowed the large heavy panel to be lifted by the wind."*

6. The Coroner went on to record:

*"The panel was one half of a large heavy wooden panel which had formed the cover of a water tank situated on the top of the plant room roof of the Blackrock building, which had long fallen into disuse. The expert evidence, which was undisputed at the*

*inquest, concluded that it had been at least 19 years since any maintenance work had been carried out on this structure which had directly led to the severe deterioration of both the timber and the corrosion of the metal fixings."*

7. The inquest determined that it had been at least 19 years since any maintenance work had been carried out on the rooftop structure, from which the rooftop debris came loose, ultimately resulting in Miss Martin's death. The Firm was responsible for the management of the building for the last five years of that period.

8. The Firm has accepted that it never explicitly identified the structures on the Roof. No request to the landlords was made to secure access to the Roof. As a result of these facts, the Firm failed to inspect, repair and maintain the structures.

9. Following the incident and subsequent inquest, a criminal prosecution was brought against the Firm and on 4 April 2019, the Firm pleaded guilty to and was convicted of an offence under the Health and Safety at Work etc. Act 1974.

10. Sentence was passed on 2 July 2019. In relation to the incident the Court confirmed:

*"In summary:*

a) *A long section of plinth which should have been securing the water tank cover was found flapping in the wind. It fitted along one edge of the panel that had struck Miss Martin. The wooden cover should have been secured by a hasp and staple arrangement, with the staple screwed to a fixing pad secured to the brickwork below, with the hasp passing over it. A nut and bolt would then pass through the exposed staple to secure the arrangement. However, the hasps and staples were corroded and the supporting timber was visibly rotten. Some pads crumbled to the touch. In some cases the staple had simply pulled out of the rotten pad, removing the wood with it. In other cases, one or more metal components remained.*

b) *The wooden cover on the ventilation duct had flown a significant distance. It should have been secured to a wooden sill secured to the brickwork below. However, the wooden sill was rotten and the metal fixings corroded.*

*Mr Bate, an experienced surveyor, found moisture readings from some of the fixing pads for the water tank cover to be "off the scale". He opines:*

*"any reasonably competent person responsible for the maintenance for the building would, on sight of the tank room housing and redundant vent housing, have been aware of the defective decoration, wet rot in the timber and corrosion in the fixings; quite simply it was obvious to see."*

*The reason for the wet rot was natural weathering which would have been avoided by normal attention to decoration. Being exposed to weathering at a high point on*

*the building, decoration at least every three years to avoid wet rot decay was required. Mr Bate's analysis based on a three-year cycle suggests decoration last took place in 1986; on a five year cycle 1998."*

11. The court found specifically that the Firm had failed to:

a. *"Identify all structures which needed to be considered, reported upon and maintained;*

b. *Conduct a suitable and sufficient risk assessment in respect of the structures on the plant room roof which required maintenance to keep them in a safe condition, to react accordingly to such risk assessment and recommend that they be maintained;*

c. *Devise, implement and properly manage an effective system to ensure that all areas of the building, including structures on the plant room roof, had been identified and were subject to routine assessment/ inspection and maintenance as required;*

d. *Take suitable and sufficient steps to prevent, so far as was reasonably practicable, the fall of any material or object so as to avoid injury to any person;*

e. *Manage/supervise its staff sufficiently effectively so as to ensure that its statutory duty was discharged."*

12. However, in sentencing the judge found that there was no disregard for, or disinterest in, maintenance of the building and commented

*"The Company has significant mitigation available to it. It has no previous convictions; it has taken considerable voluntary steps to remedy the problem as set out above; it has provided a high level of co-operation with the investigation, beyond that which will always be expected; it manages some 650 properties across the UK and has a good health and safety record with no record of previous enforcement action; it endeavours to place health and safety at the forefront of its practices; it has accepted its criminal responsibility at the earliest possible opportunity, informing Ms Martin's family before proceedings even commenced."*

13. On 4 April 2019, the Firm was convicted of the following offence:

*"On and before 23 February 2017, the Defendant, being an employer, failed to conduct its undertaking in such a way as to ensure, so far as was reasonably practicable, that persons not in its employment who might be affected thereby, including Tahnie Martin, were not thereby exposed to risks to their health and safety arising in connection with the maintenance of the exterior of the Blackrock Building, including the structures upon it, contrary to Section 3(1) and 33(2)(a) of the Health and Safety at Work etc Act 1974."*

**Introduction & Preliminary Matter:**

14. The Panel received a substantial Technical bundle of documentary evidence, running to 1335 pages, including relevant survey reports on the Mander Centre development, relating to dates both prior to and following the incident in question. It additionally had before it a Core bundle of evidence numbering 116 pages, including Coroner's Report, Certificate of Conviction, Sentencing Remarks of the sentencing Judge in the case and witness statements from representatives of the owner of the Mander Centre development, and of the Firm. It received written submissions produced by Mr Rich on behalf of RICS, and a jointly agreed written position entitled, "Joint Submission on Sanction". The import of the latter, jointly agreed submission was to the effect that the Firm admitted the charges in full, including liability to disciplinary action. The parties additionally set out a joint proposal, were liability to disciplinary action to be established, in relation to what they suggested might be an appropriate disposal in respect of sanction, publicity and costs. In addition to legal counsel, representatives of the Firm were in attendance at the hearing, as well as a number of observers, including representation from the family of the individual, Miss Tahnie Martin, who had tragically died as a result of the incident in question.

15. A preliminary point arose as to the appropriate procedure which should be followed in the case. The Panel, having taken and accepted legal advice from its legal advisor, received the parties' jointly agreed written submissions, including their agreed position in relation to sanction, publicity and costs. The Panel was careful however to remind itself that all decisions in relation to the case were appropriately and properly a matter for its independent judgement. The Panel recognised the helpful and constructive efforts of both parties to assist it in this respect, including a number of important admissions and concessions by the Firm. Against this context, the parties indicated at the outset that, in the event that the Panel, exercising its independent judgement, reached a different view in relation to the appropriate disposal of the case, parties might wish to advance a submission at that stage that it would be appropriate and in the interests of justice for a new hearing to be appointed to deal afresh specifically with the question of sanction. The Panel, having taken advice and satisfied itself that the approach proposed was a proper one, consistent with the interests of justice, and within its broad procedural discretion, was content in the unusual circumstances of this case to proceed upon this basis.

**Decision:**

16. The Panel wishes to record at the outset its sadness at the terrible human impact of the events giving rise to this case, including the tragic loss of Miss Martin's life and the injuring of her colleague, RS, with consequential profound impact on their families and friends. The Panel joins with others involved in these and the prior proceedings in extending its sincere condolences to the family and friends of Miss Martin.

17. The Panel found both charges proved in their entirety, as admitted and upon the basis of the evidence before them. In arriving at this decision, the Panel bore in mind that the burden rested on RICS to prove its case to the requisite standard of proof (the balance of probabilities).

18. Having found the Charges proved, the Panel further found that the Firm was liable to disciplinary action. In arriving at this conclusion it had regard to the RICS Rules of Conduct for Firms 2007 and to all of the evidence and submissions, and admissions, made in the case. It had no difficulty in concluding that the matters charged were liable to bring the profession into disrepute and of sufficient seriousness, both individually and collectively, to render a finding of liability to disciplinary action both necessary and appropriate.

**Sanction**:

19. The Panel bore in mind that the purpose of sanctions is not to be punitive, though that may be their effect. The purpose of sanctions is to declare and uphold the standards of the profession, to safeguard the reputation of the profession and of RICS as its regulator and to protect the public. Sanctions must be proportionate to the matters found proved. The Panel paid careful heed to the advice of the Legal Assessor and to the Sanctions Policy of RICS. It considered carefully the mitigating and aggravating factors of this case.

**Mitigating/ Aggravating features:**

20. Considering the mitigating factors in this case, the Panel noted that the Firm had no record of previous disciplinary proceedings or complaints and had not previously received advice or warnings about risks or its conduct or practice. Extensive and immediate steps had been taken by the Firm following the tragic event to remedy both the specific structural defects and to put in place comprehensive systems and procedures within its global organisation to address the risk of any reoccurrence in the future. The Firm had cooperated fully and openly with RICS in the context of these proceedings, as well as with the prior, including criminal, proceedings. It had made early admissions of responsibility throughout and had willingly and proactively assisted RICS. There had been no question that the Firm or anybody else had benefited from the oversight and tragic events which unfolded as a consequence.

21. The Panel accepted the parties' agreed position that there was no deliberate wrongdoing or recklessness, no element of bad intent in general and no question of dishonesty. The incident and its tragic consequences had arisen because of oversight/ omission, albeit ones which were entirely avoidable and could and should have been prevented. There was ultimately no good reason why the issues with the roof top structures were not identified and addressed.

22. This was moreover an extremely serious oversight which extended for a significant period of time, a total duration of some five years, being the period for which the Firm had had responsibility for the management of the Mander Centre development. It had ultimately resulted, very sadly, in the death of one and serious injury to another member of the public.

**Decision on Sanction:**

23. The Panel considered that the imposition of a sanction was clearly necessary and appropriate in this case, to mark the seriousness of the breach and its reputational impact.

24. The Panel considered all of the possible sanctions available to it. The imposition of a caution or of a reprimand in isolation would not it considered be sufficient. It considered whether or not the imposition of undertakings or conditions would be appropriate. Following careful deliberation, it concluded that these would not assist in this case, recognising the extensive steps that the Firm had already taken to address the deficiencies and learning which it had identified and acted upon with a view to avoiding any reoccurrence. Ultimately it was the responsibility of the Firm to ensure its future compliance with RICS standards.

25. The Panel considered whether it was necessary and appropriate in this case to impose the sanction of expulsion or remove the Firm's registration for RICS regulation. The Panel recognised that a case could be made for this outcome, given the seriousness of the issues which had arisen. It concluded however that this was not necessary in this case, given the extent of the cooperation of the Firm and its demonstrated commitment to address the issues which had arisen. It had demonstrated significant insight following these events and it was ultimately in the public interest for the Firm to remain within the ambit of RICS regulation. It will be critical that the Firm maintains its commitment to the lessons learned in this case, and the systems and processes it has put in place to safeguard against the risk of any future serious breach. The Panel very much trusts that this will be the case.

26. The Panel concluded that it would be appropriate in all of the circumstances of this case to impose a reprimand and a substantial fine, at a level properly commensurate with the seriousness of the case while also cognisant of the very significant fine which had already been imposed on the Firm by the criminal court. Having considered carefully the helpful submissions of the parties and all of the evidence in the case the Panel concluded that a fine of £200,000 would be appropriate. This would equate to approximately 15% of the fine already imposed by the criminal court and would, the Panel considered, appropriately reflect the seriousness of the case without being disproportionate or unduly punitive in its effect.

27. The Panel accordingly imposes a reprimand on the Firm, and orders that it pays a fine of £200,000 sterling.

**Publication:**

28. The Panel considered the guidance as to publication of its decisions. The guidance provides that it is usual for the decisions of the Panel to be published on RICS' website and in the RICS online journal, Modus. The Panel considers that this would be appropriate in this case.

29. The Panel accordingly orders that this decision be published on RICS' website and in RICS Modus, in accordance with Supplement 3 to the Sanctions Policy 2008, version 6.

**Costs:**

30. The parties had advanced an agreed position that the Firm should pay costs to RICS in the total sum of £10,000. The Panel was content to accede to this joint application and so orders.

**Appeal Period:**

31. The Honorary Secretary of RICS may require a review of a finding or penalty imposed by a Disciplinary Panel within 28 days from service of the notification of the decision, in accordance with Rule 59 of the Disciplinary, Registration and Appeal Panel Rules 2009, version 7 (the Rules).

32. The Firm may appeal against this decision in accordance with Rule 58 of the Rules, within 28 days of service of notification of this decision.