Corporate Manslaughter Seminar

Wednesday 11th June 2008 National Motorcycle Museum

BHSEA Vice-Chairman, Ed Friend

BHSEA Vice-Chairman, Ed Friend, acted as Chairman for the Day at this important Seminar, attended by over 70 Delegates at the National Motor Cycle Museum in Solihull.

Judith Donovan, HSE Board,
Non-Executive Board Member

The morning was started by Judith Donovan, Non-Executive Board Member of the HSE Board, which was newly-formed after the merger in April this year, of the Health and Safety Commission and former Health and Safety Executive.

Judith gave a sparkling introduction to the event, with her heartfelt conviction of the need for this long-awaited legislation. Touching briefly, but significantly, on the horrific record of fatalities and serious injuries each year as the motivation for the new law, Judith pinpointed the responsibility of Directors to remedy this situation. She outlined the importance of the higher penalties and described the leading role of the Police and CPS to investigate and prosecute offenders.

Judith went on to repeat the responsibility of Directors in managing a key business risk and added that, by doing so, they could also deliver other business benefits. There was plenty of guidance to help them to do this and referred to the principles in the recent Institute of Directors publication that delegates had received in their seminar pack. For all of these reasons and the fact that it delivers justice, Judith concluded by saying that the HSE welcomed this Act.

Professor Frank Wright, Warwick Law School

Our keynote speaker was Professor Frank Wright who is pre-eminent in the development of this Act and acts as a Government adviser on a number of committees and working parties.

In his presentation on "New Developments in Criminal Law and Sentencing", he gave us a sound briefing on the events that had influenced the

making of this new Act. He looked as far back as the tragic loss of life in the Herald of Free Enterprise, Piper Alpha, the Kings Cross Fire and four major train crashes in the south of England. The unfortunate occurrence of so many disasters, in such a relatively short time and all attracting damning criticism from the authorities, built up a fierce pressure of public opinion calling for "something to be done"! He placed great emphasis on the duty to promote the company's success and described the most significant factors involved.

He then described the basis of the new offence as being where a "gross" breach of a duty of care occurs to a person(s) as a result of the activities of an organisation, which owes that duty of care. The jury in such cases must then decide if the alleged conduct falls far below what can be reasonably expected under the obligations owed under the General Duties of the Health and Safety at Work Act, the Management of Health and Safety at Work Regulations, Successful Health and Safety Management (HSG65) and any other relevant guidance or standard of "best practice". It must also be proven that this conduct caused the death of that person(s).

Interestingly, Frank commented, this Act gives complete immunity from anyone who aids, abets, counsels or procures the offence, from 'secondary liability' for prosection. The Act, however, did not amend s37 in the Health and Safety at Work Act, so there is considerable potential there for a greater use of the prosecution discretion in the exercise of this power. Additionally, an individual can be convicted of manslaughter on the basis of gross carelessness, with a liability for imprisonment as well as a fine.

This new law is also complementary to a strong rise in attitudes and legal obligations to improve corporate governance in the UK and internationally, which can have the added benefit of being simultaneously good for business. Frank quoted the new **Companies Act 2006** as an example of 'non-Safety law' that supported the Manslaughter Act and cited the guidance for directors in **"Leading Health and Safety at Work"**, published jointly by the Institute of directors and the Health and Safety Commission. This document addressed the Strategic Leadership of policy, Core Strategic duties and actions and the Process for reviewing effectiveness. In total this provides a framework for saving life and staying out of court and was an essential item in the Delegates' Seminar Pack!

Frank concluded with a mention of the **Health and Safety Offences Bill 2007**, which proposes revision to mode of trial and maximum penalties for certain health and safety offences. Although this is a Private Member's Bill, it has Government support, passed its third reading on 13th June and will add even more motivation on companies to improve their Health and Safety management. He went on to say that, as a result of research by himself and a colleague on behalf of Warwick Law School, the Health and Safety Commission has said that increased use will be made of the **Directors disqualification Act 1986.**

David Clark, CPS West Midlands

Our second speaker was David Clark, Head of Complex Casework with the Crown Prosecution Service, West Midlands, whom he joined in 1988. In addition to his CPS role, he also holds a part-time appointment as the HM Deputy Coroner for Warwickshire. In presenting his "Case for the Prosecution", he outlined the structure of the CPS, and its role in advising police on possible prosecutions, reviewing cases submitted by the police, determing major charges a, preparing case for court and presenting the cases in court.

He emphasised that the CPS role was to *"prosecute cases firmly, fairly and effectively, where there was sufficient evidence to provide a realistic prospect of conviction and when it is* ***in the public interest to do so.****"* He added that the CPS Departmental Strategic Objective was to bring offenders to justice, improve services to victims and witnesses and promote confidence. This would be done by adopting a proportionate approach to determine which offenders should be charged and which should be diverted from court.
He went on to outline the national structure of thre CPS and said that the West Midlands Regional manslaughter cases would be overseen by the York office of the special Crime Division, within the CPS Headquarters.

In oder to maintain consistency, David said, prosecution decisions are governed by the **Code for Crown Prosecutors.** The first stage is to consider the evidence and, if a case does not pass this, it must not go ahead – no matter how important or serious it may be. Prosecutors must consider whether evidence can be used and is reliable. Also, a *"realistic prospect of conviction"* is an objective test of whether a jury, magistates or judge, properly directed in accordance with the law, is more likely than not to convict the defendant. On the question of Public Interest, David said this involves factors both for and against, which should sometimes be put to the court when sentence is being passed. Only where the factors against public interest clearly outweigh those in favour, wil a prosecution go ahead, or where inall the circumstances it si more appropriate not to.

Although the CPS has a statutory duty to prosecute Police cases, it may also take over cases instituted by other prosecuting agencies such as the HSE and Environment agency. This process is governed by the Prosecutors Convention and local co-ordinators liaise with their counterparts in other agencies, as part of a national framework. In cases where there is a fatality, the **Death at Work Protocol** has been signed by the CPS, HSE, Local Authorities, British Transport Police and the Association of Chief Police Officers. The key to handling such cases sensitively and effectively is the early communications between agencies and local liaison groups have been set up to ensure that these guiding principles actually work. The CPS works with the other agencies to decide how the case will proceed but, ultimately, has to decide on whether to bring proceedings for manslaughter. If not, then the other agencies may decide to prosecute under other legislation.

Finally, the issue of **"Gross negligence manslaughter"** has been established relating to *individuals* in the leading cases of ***R v Adomako 1994*** and ***R v Srivatava 2005*** and those common law principles will continue to assist in prosecutions under the new Act. The essential elements of the offence are:-

- the defendant is a qualifying organisation
- the organisation caused the victim's death

- there was a relevant duty of care owed by the organisation to the victim
- There was a gross breach of that duty
- a substantial element of that breach was in the way activities were managed or organised by its senior management

A substantial part of the failure must have been at senior level, but this does not mean that senior managers can merely delegate ***responsibility*** to junior members of staff. such an abrogation of responsibility could in itself be a relevant factor in ***demonstrating senior management failings.*** A jury ***must*** consider whether the evidence shows that the organisation failed to comply with any relevant health and safety legislation, and ***may*** consider other factors including prevailing atttitudes, policies, systems or accepted practices in the organisation.

For further information, see **www.cps.gov.uk**

Det.Ch.Insp. Steve Bimson, West Midlands Police

Det.Ch.Insp. Steve Bimson, Senior Investigating Officer, Major Investigation Unit, with West Midlands Police is the lead officer on Corporate Manslaughter invetigations and addressed the reasons for the new law right at the beginning of his presentation. He said that the "Identifaction Principle"was crucial in linking the guilt of a company to the guilt of a particular senior individual, who had to be shown to be the 'Directing Mind'. In complex organisations, it was difficult to prove an individual's actions were 'grossly negligent'.

The new law meant that there would be a change of attitude in the police service, as they became the lead investigator and would be closer to the HSE at an earlier stage, still relying on their advice for technical issues. Regarding the principles of the investigation he said that the "Golden Hour" was essential in gathering quality evidence, with the area becoming a crime scene, having a 'Manager' responsible for the collection of fingerprints, DNA evidence and photographic material. It was also necessary to identify possible other, related crime scenes as part of the process. Another vital link in the chain of evidence were the witnesses and, where these were classified as 'Significant', there may be associated welfare problems. Other important sources of evidence were CCTV and Telephone records tht must be preserved.

It was also vital for the victim to be included in the process of gathering information. A forensic post mortem was essential in establishing the exact cause/mechanism of death. It also helped the investigator to fix the circumstances at the time of death, regarding

positioning at the time of death and Toxicology. Finally, there was the gathering of expert evidence from HSE, Forensic and Industry Experts.

All of this evidence had to be tested and reviewed against the key elements of the offence, Duty of Care, Activities managed, management failings, possible Gross breach of Duty and actual cause of Death. The whole process had to be controlled by a clear Investigative Strategy, regular reviews of evidence recovered to date, a consistent approach, a secured commitmant from all partners and a rigorous timetable.

Rosi Edwards, Head of Operations
HSE Construction Group

The speaker from last of the Agencies to present their views was more familiar, in that it was **Rosi Edwards, Head of Operations, HSE Construction Group,** who has spoken to us several times in the past. In putting the new Act into context, Rosi covered the current accident returns and existing laws that imposed obligations and penalties corporations, as well as individuals. She went on to emphasise the Moral, Business and Economic cases for managing health and safety and how the real costs could be hidden in unexpected side-effects form accidents. The simple remedy for this was Sensible Health and Safety, a philosophy that HSE had been advocating for many years. This was embodied in the IoD/HSE guidance on Director Leadership, referred to by other speakers. It relied on strong and active leadership from the top and on positive involvement of Workers to implement meaningful assessment and management of risks. To be effective this process needs to be Planned, Monitored and Reviewed. Only then will directors know and understand the risks and manage procedures that are 'live' and tailored to their specific business. Rosi went on to give detailed examples of how directors could prove their diligence under the law by demonstrating effective planning, delivery, monitoring and performance reviews.

In conclusion, Rosi left us with useful links to further information and guidance and benchmarking.

George Allcock, Consultant
BHSEA Management Committee

Or final speaker was certainly no stranger to BHSEA, as it was **George Allcock, past BHSEA Chairman, present Management Committee Member** and a member of the Seminar Organising Committee. Until recently, George had worked for many years as Group Safety Advisor for GKN and has a wealth of experience in developing and managing health and safety in a multi-national engineering company.

George's message was that because serious injuries are, thankfully, rare it often results in blind spots that can lead to death and serious injury. Managing "High Severity –Low Frequency Accident" risks, therefore, is a real challenge for many businesses. The only safeguard is to have a robust system of safety mangement in place to anticipate what might occur and George posed a series of questions for Directors / Senior Managers that could form a possible agenda for discussion at Board Meetings or Safety Committee Meetings. They included types of potential accidents, how they could happen and why, what is our actual health and safety performance and how does it compare, how effectively are we managing the risk of serious or fatal accidents AND If things go wrong, will I be held responsible? FINALLY – What can I/we do about it?

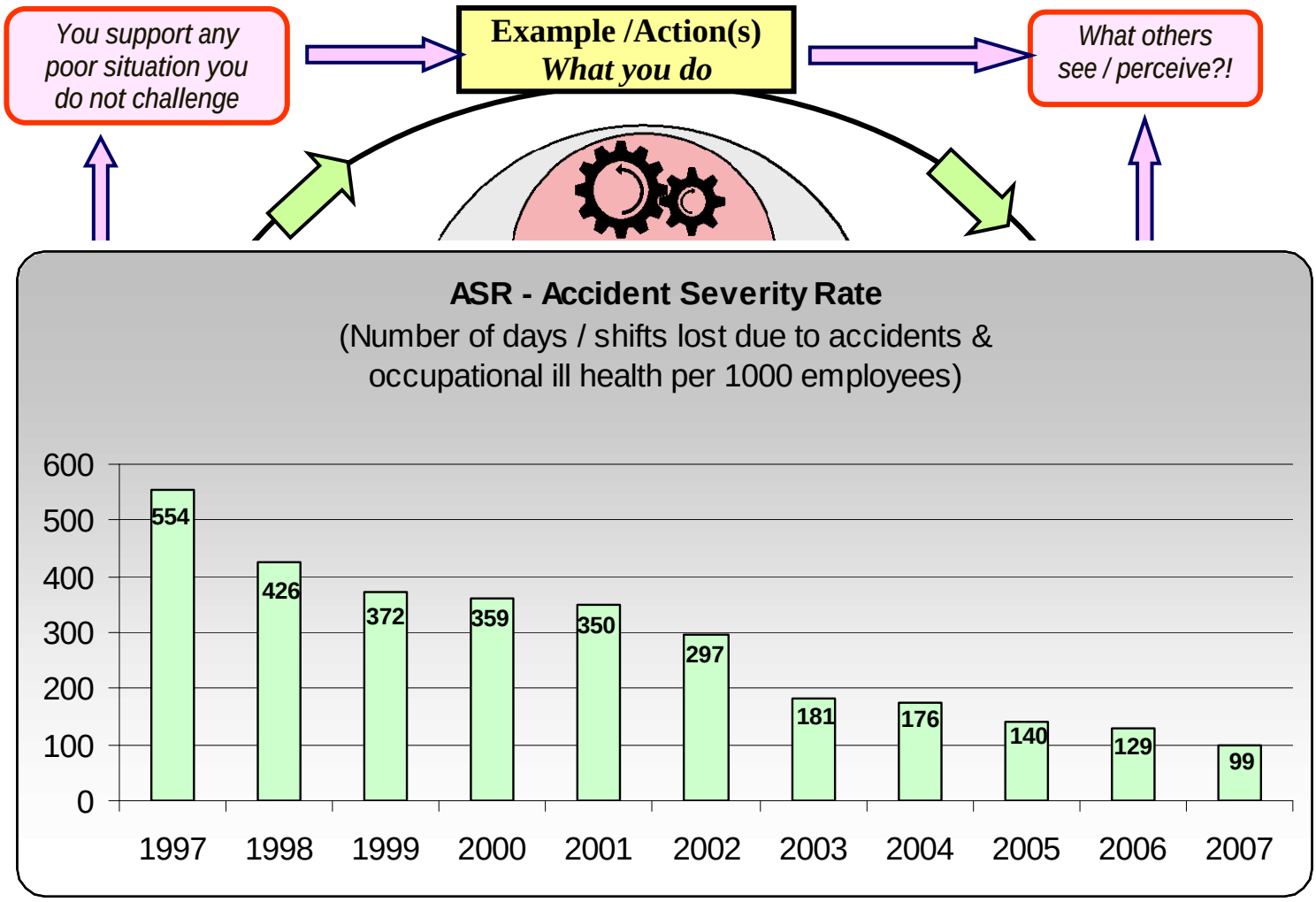
George reminded us that accidents are almost invariably caused by a combination of causes, such as poor engineering standards, system failures or sub-standard behaviour. not all of these may be under the control of the victim or anyone else directly involved. This means that there is always scope for management improvement! As a small test for the audience, George presented a short, practical reminder on causes of accidents, citing typical engineering examples. He also displayed examples of actual Accident, incident and Near Miss reports, with photographs, to demonstrate the simple way of bringing the lessons home to managers and workforce alike. It is also an excellent way of encouraging commitment to implementing ***"Improvement Opportunities"*** He than drew comparisons between **Poor Performers** and **Good/Excellent Performers** on a 12 element chart, confirmed by benchmarking several management units. The good performers were obviously well-manged team players, in manageable sized cells, and George went on to show us more of how these systems relied on simple visual techniques to make people more effective. At the heart of the system is the RADAR technique **R**isk, **A**wareness, **D**etection, **A**ction & **R**eview and an example of Visual Information/Posters – Safe *vs*, Unsafe Behaviours.

The system also looked at the A-B-C of Leadership style, behaviours, actions and feedback that have such a strong influence on the **A**ntecedant (or Trigger), **B**ehaviour (an observable act) and **C**onsequence(s). When "walking the job", all managers have to do is ask simple questions like: -

- Can you tellme/show me how you do this?
- How do you know you are doing this correctly/safely?
- what do you do if you have a problem?

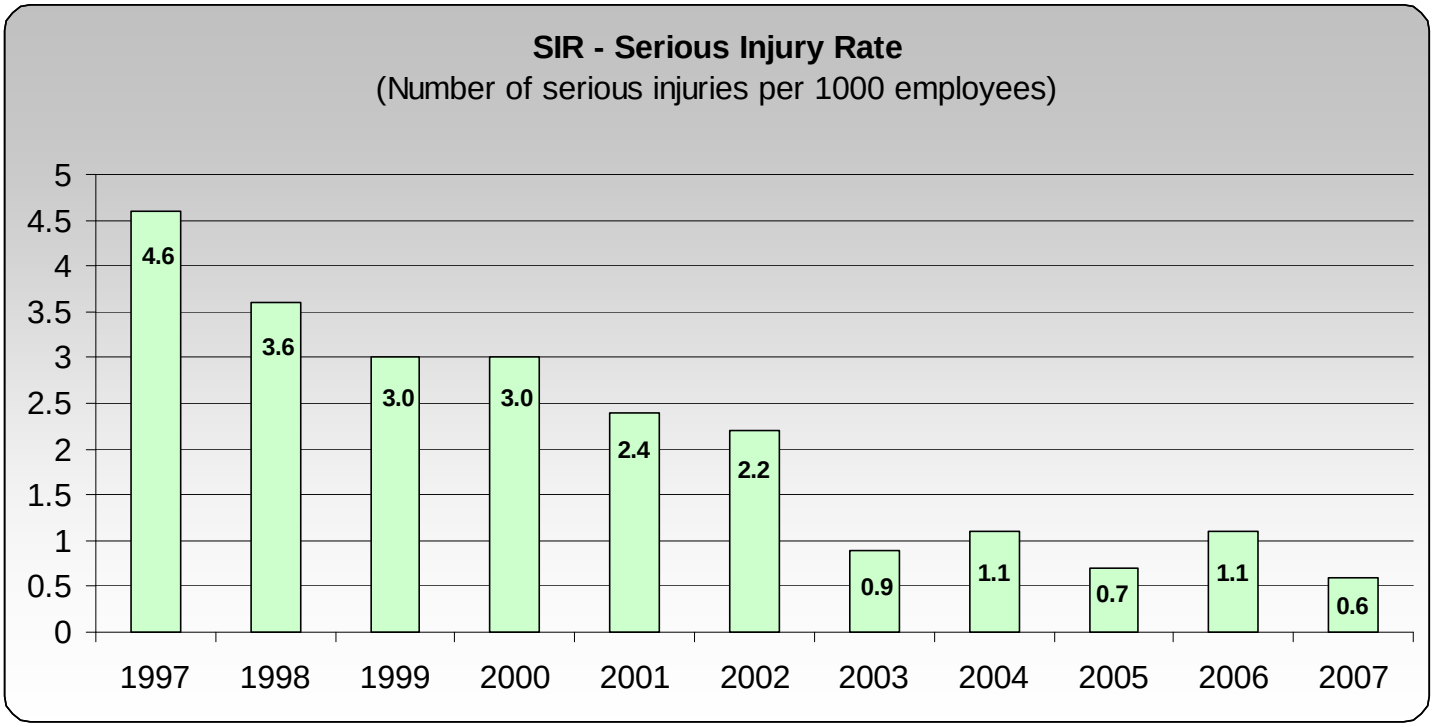
to show a genuine interest in the job and their workforce and encourage more involvement on the shopfloor.

George concluded with the theme that Leadership is the Key Factor and gave us this diagram that summarised the salient elements: -



Performance Improvements – Days Lost

Just to prove the point that the basic principles can actually work in practice, George also producesd these charts to show that GKN had achieved some impressive results with this approach. These figures were from information first published in the GKN Annual Report & Accounts, which just goes to show how the more progressive companies keep abreast of the most up-to-date best practice!



Performance Improvements – Serious Injuries