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Metadata Record: https://dspace.lboro.ac.uk/2134/10818

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CORPORATE KILLING
The Proposed Criminal Law Offence for Manslaughter at Work

by
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A Master's Thesis
Submitted in fulfilment of the requirements for the award of

Master of Philosophy
of
Loughborough University

Date January 2000

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ABSTRACT

The focus of the study was to research the success and failure of Corporate Manslaughter cases under the present law, and to identify the management systems that a corporation would required, to meet the obligations for health and safety under the proposed offence of Corporate Killing. A review was made of the rationale between the successful small company prosecution where there is considered to be hands on management to the prosecution failures of large companies where the management are deemed to be remote from an incident. To obtain a base line, a review was made of the proposed offence of Corporate Killing, which involves a substantial revision of the homicide offence of manslaughter. This clearly identified that the new offence is encompassed in the failure of health and safety management, rather than gross negligence of an individual or individuals.

As a foundation, two data bases were researched and developed to provide deaths at work profiles. The first data base identified cases that were submitted to the Crown Prosecution Service for review for Corporate or individual manslaughter. The summary of the data showed that there were 86 cases of which 39 cases were not progressed, and only in 6 cases were there guilty verdicts. A second data base was developed identifying cases where there had been a death at work and where there were no manslaughter prosecutions, but there were charges laid under the Health and Safety at Work etc 1974 and Regulations, with the resulting outcome of penalties levied.

The key words for the study are; Corporate Manslaughter, Safety Management, Manslaughter, Death at Work, Fatal Accident, Crown Prosecution Service, Health and Safety Executive, Law Commission, Criminal Law.
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CHAPTER 1 - INTRODUCTION

The purpose of the study was to examine the existing status of cases pursued for manslaughter at work involving a corporation, against the proposed criminal offence of Corporate Killing, and the implications for companies and directors under the new offence. The study identified the momentum of a public demand for a specific offence against corporations, and in particular those who control them, in cases where there are deaths at work. There were eight disasters that caused the public great concern because with the exception of one case, no manslaughter charges were laid. The eight incidents encompassed a four year period resulting in 625 deaths which included the 1985, Bradford City Football Stadium, 49 deaths; 1987, the Herald of Free Enterprise, 154 deaths; 1987, the Kings Cross disaster, 38 deaths; 1988, Clapham Rail, 37 deaths; 1989, Piper Alpha, 165 deaths; 1989, Purley Train crash, 5 deaths; 1989, the Bowbelle - Marshioness incident, 51 deaths and 1989, Hillsborough, 95 deaths. There have been other incidents with loss of life since that period but the fact is that only two large companies have faced manslaughter charges, those being P & O European Ferries (Dover) Ltd and Great Western Trains Ltd, and neither of these prosecution cases were successful. The objective of the new offence of Corporate Killing is to enhance health and safety at work and provide sanctions that will have far reaching consequences for all organisations, particularly those in control of them. (Law Commission 1996)

There are accepted problems with regard to manslaughter at work prosecutions under the present homicide law. These have evoked a movement of public opinion to have the directors of corporations held responsible for the management failures in respect to deaths at work, where there has been a perceived disregard for health and safety by the boardroom management. The result has been for the Law Commission to produce
proposals for changes to the current definitions of manslaughter, which when adopted will introduce into statute an offence of Corporate Killing. (Law Commission, 1996) The aim is to bring corporations, who fail to ensure the safety of those they employ, and those who are not employed but who are affected by the activities of the corporation, into the sphere of the criminal law of manslaughter. The current status of manslaughter at work requires an individual to participate in an act or have direct knowledge and sanction an act where an individual or a number of persons die. With a large corporation, identifying that person has proved, to date, to be impossible and so the focus of the proposed change in the law will move the emphasis away from the individual to the management of the corporation. It is acknowledged that the employer is already liable under Sections 2 and 3 of the Health and Safety at Work etc Act 1974 (HMSO 1974) and therefore, it is questioned as to what value the new offence would have on the way management views its responsibilities concerning health and safety and deaths at work.

1.1 THE HOMICIDE ACT

Corporate Killing will be an offence in English criminal law involving deaths at or due to work and will be an offence of homicide. It is not the intention to describe in detail the criminal law of homicide which encompasses murder and manslaughter, but to provide an overview of the key elements and their status in the current criminal law. The constituents of Homicide are adequately described by Smith (1999) as follows:

‘The Actus reus of murder and manslaughter is generally the same. It is the unlawful killing of any person ‘under the Queens Peace’, the death following within a year and a day.’

It must be proved that the defendant caused the death of the deceased person. At common law homicide was committed only if the death occurred within a year and a day of the act of causing death. That rule was abolished by the Law Reform (Year and a Day Rule) Act 1996. If an act can be shown to be the cause of death, it may now be murder, or any other homicide offence, or suicide, however much time has elapsed between the act and the death. The Act, however, requires the consent of the
Attorney General to the prosecution of any person for murder, manslaughter, infanticide, or any other offence of which the elements is causing a person's death, or aiding and abetting suicide, (i) where the injury alleged to have caused the death was sustained more that three years before the death occurred or (ii) where the accused has previously been convicted of an offence committed in circumstances alleged to be connected with the death.

Manslaughter is described by Smith as a complex crime of no less than five varieties. It covers three cases where the defendant kills with the fault required for murder but, because of the presence of a particular extenuating circumstances recognised by law, the offence is reduced to manslaughter. These cases are traditionally known as 'voluntary manslaughter'. The other cases - 'involuntary manslaughter' - consist of homicides committed with a fault element less than that required for murder but recognised by the common law as sufficient to found liability for homicide. It should be emphasised that there is only one offence. Whether the defendant is convicted of the voluntary or involuntary variety, he is convicted simply of manslaughter. A life sentence is mandatory for murder, but for manslaughter the maximum is life and there is no minimum sentence set. It is an offence which may be committed with a wide variety of culpabilities and sometimes may be properly dealt with by a fine or a conditional or absolute discharge.

The law might be summarised as follows:

A person is guilty of manslaughter where:

(a) he kills or is a party to the killing of another with the fault required for murder but he acted:

(i) under diminished responsibility (s2 Homicide Act 1957)
(ii) under provocation (s3 Homicide Act 1957)
(iii) in pursuance of a suicide pact (s4 Homicide Act 1957)

(b) he is not guilty of murder by reason only of the fact that, because of voluntary intoxication, he lacked the fault required; or

(c) he kills another:

(i) by an unlawful and dangerous act; or
(ii) being (a) grossly negligent as to death or (b) reckless (in the Cunningham sense) as to the death or serious harm; or, possibly; (c) grossly negligent as to serious bodily harm or (d) reckless as to any bodily harm.'
A person cannot ordinarily be found guilty of a serious criminal offence unless two elements are present: the *actus reus* or guilty act and the *mens rea* or guilty mind. A wrongful act on its own therefore cannot usually be criminal unless the wrongful state of mind required for that offence is also present. The *mens rea* for murder is malice aforethought, and that term has been made clearer through a House of Lords decision. The case of *Moloney* (1985) involved a soldier who became involved in a heated discussion with his stepfather about guns. The stepfather goaded him that he would not dare to fire a live bullet. At that point Moloney fired a loaded gun at him and killed him. The case focused on the definition of malice aforethought, and the House of Lords determined that nothing less than the intention to kill or cause grievous bodily harm would constitute malice aforethought (Giles, 1996).

Where there has been a death, but the key element of intent is missing, the offence is reduced to that of manslaughter. There are two categories of manslaughter: voluntary and involuntary manslaughter. In the case of voluntary manslaughter the defendant has the *‘mens rea’* and *‘actus reus’* for murder but there were circumstances that offered some form of excuse for his conduct. On this basis, murder can be reduced to manslaughter on the grounds of provocation or diminished responsibility. These two manslaughter options are not offences in themselves but form a partial defence to murder. Involuntary manslaughter is unlawful homicide, but the *mens rea* for murder is not present. This is further divided into unlawful act manslaughter and manslaughter by gross negligence or recklessness. Unlawful act manslaughter is determined by an unlawful act, *Church* (1966) which a reasonable person would realise creates a risk of injury, and death results. The defendant need not foresee the risk of death, nor need it be reasonably foreseeable (Giles, 1996).

Manslaughter by gross negligence occurs where there is an act or omission of negligence that goes beyond the civil law concept of negligence. The act or omission would be so extreme that criminal liability would be the outcome. The determination of the degree of negligence is a matter of legal process through the courts *Adomako* (1995). It will be a matter for the jury to determine the degree of negligence to identify that there was gross negligence (Giles, 1996).
The *actus reus* and *mens rea* of a corporation are raised by Clarkson (1996) who states:

‘The criminal law was developed as a mechanism for responding to individual wrongdoing. Individuals can be held responsible and blamed for their actions. Stigmatic punishment can be used to mark the appropriate degree of censure. Particularly when dealing with crimes involving *mens rea*, such individualistic notions of responsibility do not naturally encompass artificial organisations and could only be applied by humanising companies in the sense of breaking them down, metaphorically, into their underlying human components to see if there was an individual within the company who had committed the *actus reus* of a crime with the appropriate *mens rea*. This individual must be sufficiently important in the corporate structure to be said to represent the company’s directing mind and will, and for his or her acts to be identified with the company itself; in such circumstances they could be directly criminally liable (as well as the individual). This identification doctrine became established and the main route to the imposition of corporate liability, at least for crimes involving proof of *mens rea*.’

There are reforms proposed in the Law Commission Paper No 237 (1996) and discussed by Giles (1996), where there are recommendations to abolish the offence of unlawful act manslaughter. That would leave the offence manslaughter by subjective recklessness, causing the death of another by being subjectively reckless as to whether death or serious injury occurred. The Law Commission leaves open the case for a separate category on manslaughter by gross negligence.

1.2 THE CASE FOR THE OFFENCE OF CORPORATE KILLING

Current law manslaughter requires there to be gross negligence by an individual who can be identified. It is the failure to identify that person that removes the culpability from Corporate Manslaughter. The proposal is to transfer the foundation of a death at work from negligence of the identified individual to the failure of management within the corporate body. Therefore the proposed offence of Corporate Killing will focus on the failure of the management as being the cause of a person’s death and that the
failure is of a nature that it falls below what can be reasonably expected from a corporation in the given circumstances.

For clarification, the management failure is focused upon the manner in which its activities are managed or organised in that they fail to ensure the health and safety of those employed or affected by those activities. Furthermore, the failure of the corporation can still be identified with the death even though there may be a failing by an individual.

The subject of corporate culpability is raised by Clarkson (1996) who states:

'If it is the company that is culpable, then it is the company that deserves prosecution and punishment. When dealing with individuals, nobody would seriously argue that someone other than the culpable agent should be prosecuted on consequentialist grounds. If blameworthy individuals within the company can be pinpointed, one might well wish to prosecute them additionally. However, prosecution of such individuals alone might be pointless and inappropriate as it ignores the corporate pressures that might have been placed upon them by the corporate structure. One might simply be punishing the 'vice president responsible for going to jail,' and the institutional practices and pressures will continue after the sacrifice. Even with small close-held companies there is a strong case for criminal liability and removing any illegal profits, as in such companies the directors will usually be the shareholders and so will be penalised by a loss of profit, and encouraged to correct the practices that led to the wrongdoing.'

The case made by Clarkson (1996) supports corporate liability when there is a clear management failure and follows the doctrine that those who create the hazards and risks must control them, and is argued that there should be no difference between individual and corporate liability, by stating:

'Companies should be liable for the same offences as individuals and subject to the same normal principles of criminal liability. With regard to the *actus reus* requirements, the first issue is whether it was the company’s positive acts (for example, pumping effluent into a river) or omissions to act (for example, failing to
implement a safety system that caused the prohibited harm. With regard to omissions it has been argued that it might be necessary to impose a general duty upon corporations to prevent their operations causing harm. However, such a measure seems unnecessary as such companies could almost inevitably be construed as having created a dangerous situation by operating in an unsafe manner, and therefore, would be under a common law duty to prevent the dangers materialising. The problem of establishing corporate causation should be no greater than in cases of human causation. What about the case where it is the actions or inaction of an employee that directly lead to the prohibited result? Again, the solution seems clear. If the employee is acting within the scope of his or her employment and duties, the company cannot claim it did not cause the result. To emphasize this point, the Law Commission has proposed an express provision that a management failure can be a cause of a person’s death, even if the immediate cause is the act or omission of an individual. With regard to the culpability (or mens rea) requirements for more serious crimes, a company through its corporate policies and procedures can exhibit its own culpability. Manslaughter, for instance, can be committed by gross negligence. If a company blatantly fails to institute the necessary safety procedures, gross negligence can be attributed to the company itself.

The case presented for the offence of Corporate Killing is a very limited one as there are numerous issues that are raised in other chapters, but it does show that such a case is viable, and will encompass the corporation and its management failures as opposed to only individual culpability.

1.3 THE CASE AGAINST THE OFFENCE OF CORPORATE KILLING

The proposed offence of Corporate Killing has its opponents although there is limited written discussion. Opponents, who argue against the offence, raise the question as to the need for such an offence and consider the current health and safety offences are sufficient and provide an adequate deterrent.

Tyler (1999) raises the important point that manslaughter is a very serious offence, with a maximum punishment of life imprisonment and therefore, charges of manslaughter should be reserved for only the most serious of offences. The Crown Prosecution Service (CPS) reviews cases for homicide offences and refers to the CPS.
code which determines that there has to be ‘a realistic prospect of conviction’ and ‘be in the public interest’, which means that only the strongest cases proceed. Tyler provides an example with the sinking of the Herald of Free Enterprise and the prosecution for Corporate Manslaughter of P & O European Ferries (Dover) Ltd. The case which was examined at a public inquiry, was chaired by a High Court Judge, and a Corporate Manslaughter prosecution failed with no case to answer.

Tyler (1999) questions whether the proposed offence will be anything more than an aggravated form of contravention of the general duties under Section 2 and 3 of the Health and safety at Work Act, for which exactly the same penalty of unlimited fines is proposed for the offence of corporate killing. He states:

“let us be quite clear that when it comes to corporate crime in this area we are talking about accidents, not intentional, premeditated or malicious attempts to kill and injure”

His case then focuses on providing a warning against identifying negligent companies and their management as violent criminals, with the basis of his argument focusing on two main points.

“That work related deaths are in some sense tolerated within the existing legal systems; and that characterising management failings as traditional criminal offences of violence works as an effective deterrent”

Tyler further provides the argument that there is intent in insider dealing and fraud, but with incidents of workplace accidents they are not intended but are the consequence of unseen failures to identify and control risks. It therefore follows that it is difficult to determine how deterrence can be effective for individuals in often complex corporate structures. He extends the view that there is no evidence that the deterrence factor will have an impact in reducing workplace accidents.
1.4 CORPORATE MANSLAUGHTER

Those campaigning for manslaughter at work prosecutions believe that it is not legal difficulties that result in failure to bring prosecutions but a lack of will by the HSE, Police, CPS and the Judicial system to identify companies which endanger their employees. They also believe only the threat of prison sentences for company directors will be an adequate deterrent. Fines for corporate manslaughter may not be significantly higher than fines for offences under Health and Safety at Work legislation, which are widely regarded as inadequate (Christian, 1999).

There are a number of elements that are considered to be the key ingredients of a Corporate Manslaughter case, which highlight the failure within a corporation if not adopted, but if they are adopted by a corporation, offer a defence against the prosecution case or mitigation in the event of a successful prosecution. The 'identification' and 'corporate culpability' aspects are issues that are more readily identifiable within a small company with a single director, where the blame can be squarely put on the individual. This is evidenced by the successful prosecutions for corporate and individual manslaughter in two such cases. However, that process has not applied in a larger corporation, where the culpability of the directors is considered to be remote from the cause of death because nobody has been identified and therefore there is no case to answer. It is with the larger corporations that the failure to prosecute and achieve a successful outcome arises and draws upon public disquiet. It is that public concern over the lack of blame being placed on directors when people have died as a result of workplace activities that, they see blame being placed upon employees when the 'controlling minds' of the corporation have disregard for safety and health.

1.5 REGULATING AUTHORITIES

The key organisations involved in Corporate Manslaughter prosecutions are the Health and Safety Executive (HSE), the Crown Prosecution Service (CPS), the Police and the Coroner. Each organisation has its own guidelines for undertaking its business and it is evident that they differ considerably, although the 'aim' is the same,
which is to identify the cause of a fatal accident due to an 'at work' situation and, if appropriate, prosecute those responsible. It is the evolution of the prosecution process that causes the problem, and it is the aim of the new offence to enable the authorities to place criminal liability for the serious offence of manslaughter on the corporation. It is proposed that individuals, who are 'identified' as having been grossly negligent, can still be open to prosecution for manslaughter as an individual, which is the case at present.

1.6 FINES AND PROTOCOL

It is argued by Wells that fines for health and safety offences are considered to be extremely low both in terms of penalty available and financial penalties imposed, and this extends to cases where there has been a fatality (Wells, 1993). The status of fines is also the focus of a point raised by Clarkson, who quotes the Director General of the HSE, who states:

'the law was specifying higher penalties for the death of bluebells than people.'
(Clarkson 1996)

The case is also put by Wells that the public considers that corporate crime goes unpunished, where directors do not carry personal blame, because the corporations are fined and fines do not reflect the seriousness of the offences (Wells, 1993). The level of financial penalties for health and safety offences is the subject of review for the Magistrates' Courts, where the majority of cases are heard. If having heard the evidence of a case the Magistrates consider that their powers of sentence do not reflect the seriousness of the offence, they can send the case to the Crown Court for sentence by a judge, where the fines are unlimited. There is also progress in addressing the Corporate question through the introduction of the protocol of co-operation between the HSE, Police and CPS in death at work cases (HSE, 1998). The aim is for the authorities to co-operate in the investigation and identify those cases that warrant progression to Corporate Manslaughter, under the present legal definitions of manslaughter.
1.7 CORPORATE KILLING

It is proposed that a new offence of Corporate Killing (Law Commission 1996a) should be implemented by the Government which will allow the regulating authorities to prosecute companies where people die as a result of failures at the boardroom level. The introduction of this new offence, based upon the Law Commission's Report 237 will have implications for all corporations, as well as the enforcing agencies, including the CPS, Police and HSE. The research project examines the existing status of Deaths at Work and Corporate Manslaughter cases and through the development of two databases, evaluates the implications of the proposed new offence of Corporate Killing.
CHAPTER 2 - MANSLAUGHTER AT WORK CASES

The subject of deaths caused through work, and the public demands for liability to be placed with the directors is emphasised through the media in articles such as that by Dewis (1992) entitled Causing Death by Dangerous Management? where he states:

"The disasters which involved large numbers of the general public in the 1980's - Zeebrugge, Bradford City, Hillsborough, King's Cross - seemed to lead to a general consensus that criminal law should be able to reach up, identify and impose liability at a high corporate level. The obvious target is a board of directors, individual departmental directors with a safety brief and senior members of management."

Because there is no offence in statute of Corporate Manslaughter, it has caused untold problems for the authorities who are tasked with investigating and prosecuting manslaughter at work cases. The problem has been well documented over a number of years with examples such as that recorded in the publication, Hazard (Anon, 1994)

"In October 1994, British Rail and Tilbury Douglas Construction were fined just £25,000 for breaches of criminal law including 'serious mistakes by both defendants'. The case followed the deaths of two workers and hospitalisation of five others in the June 1992 collapse of St John's Bridge at a BR south London demolition site.......A year before British Rail and Tilbury Douglas were fined following the accident which led to the deaths of (two) construction workers......a jury at Southwark Coroner's Court had returned an 'unlawful killing' verdict on both deaths....After the inquest the case was referred to the Crown Prosecution Service (CPS) to see if manslaughter charges should be brought against the firms. The CPS would not recommend prosecution, saying there was insufficient evidence to secure a conviction.........."
The article extends the problem further into the legal system when it identifies that:-

"Judges are finding fault with a system that consistently lets employers off lightly. Judge George Bathurts - Norman, on sentencing Richard Baldwin, chairman and director of Baldwin Industrial Services Ltd of Slough, said, ‘If prison were an option open to me today you would be sent to prison’. Baldwin was personally fined £20,000 and the company fined £70,000 after they pleaded guilty after failing to do safety tests on cranes and falsifying test certificates.....".

In 1995 six people were killed and seven others seriously injured when a ferry walkway at the Port of Ramsgate collapsed, and the company was prosecuted under health & safety legislation. The outcome of the trial was a record fine of £1.7 million. The question posed by Dix (1997) asks, what are the implications of such a fine for companies? He continues to provide an answer by stating:-

"Unfortunately, the sentence is not designed to ensure that any faults within the companies' systems will be examined and rectified. The objective of sentencing a company found guilty of a breach of Health & Safety regulations should be to punish, to deter and perhaps most important of all, to rehabilitate. Under the present legislation, however, the only sentencing option for a judge is a monetary fine.......companies may very well be dismayed at the potential damage to their reputations, a fine does not have a rehabilitating effect......the original charges brought against the companies do not reflect the seriousness of the crimes......The companies could have been charged with the same offences even if the walkway collapse had not caused any deaths or injuries. While we can accept that there was no intention to cause injury, a charge that reflects the level of harm done would be more appropriate."

The strength of the argument therefore, lies with the evidence that the current law places fatal and non fatal accidents under the same legislation with those considered to be more serious, being submitted to the CPS for consideration for manslaughter. It is a requirement to prove gross negligence of an individual or individuals to obtain a conviction for manslaughter that causes the cases not to be progressed or to fail at court.
This is further clarified by Gobert (1994) who stated;

"The problem with regulatory laws, as administered in practice, is not simply that they appear to undervalue the harm which has occurred. Sometimes that harm is the result of fortuitous circumstances, and prosecution would exaggerate the degree of the company's fault. The greater problem is that regulatory laws may not exert sufficient deterrent force to prevent violation. Most companies strive to maximise profits. The rational corporate brain trust might well reason that if the company violates the law and the violations are not discovered, but the company complies in the future, nothing is lost. In the interim the company may have prospered, perhaps even to the point of eliminating a less unscrupulous rival; at worst it will have saved the costs of compliance for the period in which it was in violation of the law. If prosecuted, most commonly in a magistrates court, the company faces a maximum penalty of £5000*, an amount which has been aptly compared to the equivalent of a parking fine for an individual. Thus there is little economic incentive for a company to obey the law, and as a rational profit maximises, it might seem economically foolish for it to do so."

* Note: Maximum penalty now £20,000

Manslaughter cases resulting from deaths at or due to work pose a number of problems, and Wasik (1994) identifies the following points:

"When is it appropriate to proceed under health and safety regulations, and when to charge with manslaughter? The main problem in sentencing for manslaughter is the wide variety of factual situations in which the offence may be committed, across which the full range of penalties (from discharge to life imprisonment) is available. In Walker, Lord Lane said that: Of all crimes in the calendar, the crime of manslaughter faces the sentencing judge with the greatest problem, because manslaughter ranges in its gravity from the borders of murder right down to those of accidental death."
While the courts have problems with sentencing, there is the situation of non-acceptance by management of the responsibility for health and safety within a corporation. Key issues are raised by Allen (1997) who states:

"....the more diffuse the company structure, the more it devolves power to semi-autonomous managers, the easier it will be to avoid liability....This is of particular importance given the increasing tendency of many organisations specifically to decentralise safety services. It is clearly in the interest of shrewd and unscrupulous management to do so.......If corporations perceive themselves to be at risk of prosecution for corporate manslaughter, an analogous process of decentralisation within the corporation might be developed to evade liability.......Priorities in hierarchical organisations like corporations are set predominantly from above. It is these priorities that determine the social context within the corporation's shop floor workers and the like made decisions about working practices. A climate of safety or unsafety may permeate the entire organisation but is created at the highest level........A key issue of the seriousness with which a corporation treats safety is the development of clearly delineated responsibilities for the scrutiny and revision of safety procedures."

Concerns about Corporate Manslaughter at work have permeated a wide range of areas, including the European Community, where Oddy (1995) produced a written question:

"According to the UK Law Commission, there have been over 5000 workplace deaths in the last ten years but only one criminal prosecution for manslaughter. Will the Commission consider an action programme under the White Paper on social policy to ensure that employers' liability for the deaths of employees is taken more seriously."

An answer was provided by Mr Flynn (Oddy, 1995) replying on behalf of the Commission who stated:

"Penal law is within the competence of the member states. However, the Commission takes very seriously the need to ensure respect for Community law, and in particular health and safety legislation. Member States have to ensure that
The opening discussion identifies major concerns within the legal system in dealing with manslaughter at work, of which there has been a limited number of cases that have been prosecuted, following a death resulting from work, for corporate liability for manslaughter. There is no offence in law for corporate manslaughter and as described in the Law Commission Report No 237 there has to have been gross negligence on behalf of individual defendants, who could be ‘identified’ with the company and who would themselves be guilty of manslaughter (Law Commission 1996a). In some cases it may be employees who are killed while in others it is members of the public. All have the common thread that there have been serious failings in the management of health and safety. The Health and Safety at Work etc Act 1974 determines that it is the duty of the employer, in another words the board of directors of a company, to ensure health and safety of those who are employed, as well as those who are not employed. To meet these obligations in their most basic form, corporations must provide a health and safety policy outlining the companies standards and objectives with regard to health and safety. That policy must be adopted and signed by the most senior person of the company. Even if this has been done, the argument is made that directors do not have ‘hands on’ control of the company and therefore cannot be reasonably liable for any failings within the company. For example it was argued that the managing director of P & O European Ferries, was not aboard the vessel at the time of the Herald of Free Enterprise disaster and therefore, could not be liable for what went wrong. On the other hand in the cases of Kyte and the Lyme Bay Canoe Tragedy (Knight, 1994), and Jackson and Jackson Transport (Joliffe, 1996), it was argued that, although they were directors, because they were operating in a ‘hands on’ manner, they had first hand knowledge of the situation. It followed that they were reckless in that they did nothing to eliminate or reduce the risks to employees and those not employed, but affected by the activities of the business. Therefore it becomes evident that small ‘one man’ type companies can be held accountable whilst, in large corporations, the ‘controlling minds’ of the company can hide behind the remoteness of their positions. This is the case even though they may have had knowledge of failings with safety within their
organisations. Therefore, because there is no specific offence of Corporate Manslaughter it has proved difficult, if not impossible, to identify an individual within a large corporation who had the direct responsibility for the management of health and safety.

The case for corporate culpability is made by Clarkson (1996) who states:

"The Law Commission's proposed general test for the offence of killing by gross carelessness can easily be applied to companies. The issue would be whether the risks would have been obvious to a reasonable *corporation* in that position and whether the *corporation* had the capacity to appreciate the risks. Of course, this latter requirement that the company have the capacity to appreciate risks will be of little significance in practice because a company, by definition, will necessarily have this capacity if the risks are obvious. However, it is important, if corporate killings are to be condemned appropriately, that liability be limited not only to those cases where the company's conduct fell far below what could reasonably be expected, but also to cases where the risks would have been obvious to other companies in the same situation. Application of the same test to both individuals and companies will serve to emphasise that corporate offences are not 'poor cousins' of crimes committed by individuals. The Council of Europe has proposed that whenever a company's activities or those of its employees lead to a prohibited harm, the company should be *prima facie* liable; the evidential burden would then switch to the company itself to prove that it had a safe system that could not be faulted."

The issues raised by Clarkson show that the case for corporate culpability is not just a matter for domestic law but of European law.

2.1 CORPORATE MANSLAUGHTER CASES

In recent years a number of tragedies have brought demands from the public for the use of the law to charge corporations with manslaughter at work offences. However, there is also evidence that public opinion considers it wrong if all the blame is placed on a junior employee. If it is the directors who determine the operational philosophy
as the 'controlling minds' and have the most to gain from the corporation then they should carry the overall responsibility. (Law Commission, 1996b) A review of the manslaughter at work cases reveals that there have only been six prosecutions for Corporate Manslaughter. They are Cory Bros Ltd in 1927; Northern Stripping and Mining Construction Ltd in 1965, P&O European Ferries (Dover) Ltd in 1987, Kite and OLL Ltd in 1994, Jackson and Jackson Transport (Ossett) Ltd 1994 and Roy Bowles Transport Ltd 1999 (Harvey 1999).

It had long been thought that a corporation could not be guilty of manslaughter, because the law of homicide required the killing of a human being to be done by another human being. This was the basis of the decision in Cory Bros Ltd, in 1927 in which Finlay quashed an indictment against a company for manslaughter. It was clear that he found himself bound by earlier authorities, which he concluded showed 'quite clearly' that an indictment would not lie against a corporation for a case involving personal violence. The case of Cory Bros was, however, decided before the principle of 'identification' was developed. (Law Commission, 1996c)

The case of Cory Bros Ltd, 1927, was a private prosecution brought by the deceased's brother through the South Wales Miners' Federation. The basis of the case involved the directors of a private mining company, who during the miners strike of 1926, erected a fence around a power house belonging to the company. It was done, in their minds, as a protection against pilfering by strikers and their families. However, to make the fence totally effective it was electrified. The deceased, an unemployed miner was scavenging close to the fence, he fell against it and was electrocuted. The South Wales Miner's Federation determined that the company and three of its engineers had set a predetermined mantrap and supported the private prosecution against them for manslaughter. Committal proceedings against the company and the engineers were successful but it was determined that the law did not allow an indictment to lie against a corporation for an action that was set out in the indictment. The charges against the three individual engineers remained and they were prosecuted, but the outcome resulted in acquittals (Wells, 1994a).
Although it was a slow process the attitudes of the courts changed over a period of time and is highlighted in the case of *Northern Strip Mining Constructions Co Ltd*, 1965. The case involved a welder-burner who was drowned when a railway bridge which the company was demolishing, collapsed. Employees had been instructed to burn down sections of the bridge, starting in its middle. At trial the defendant company was acquitted on the facts of the case, but neither counsel nor the presiding judge appeared to have any doubt about the validity of the indictment; and the defence counsel seems to have concurred with those opinions. It was reported in *The Times* 4th February 1965 that the judge argued that it was the prosecution's task to show that the defendant company, in the person of the managing director, was guilty of such a degree of negligence that this amounted to a reckless disregard for the life and limbs of his workmen. The Law Commission Report (Law Commission, 1996d) concludes that there is no awareness of any report of the argument, or of the judge's reasons.

There were a number of disasters encompassed within a four year period from 1985 to 1989 that really focused the public's attention on the total lack of corporate liability for deaths caused by boardroom failures. The cases are examined by (Wells 1993), identifying the first incident which occurred in 1985, when 49 people died in the Bradford City football stadium fire. The wooden stand caught fire, possibly as result of a cigarette being discarded in rubbish accumulated under the stand over a long period of time. In 1987 there were two tragedies and it was the *Herald of Free Enterprise* that pushed the failings in corporate liability to the forefront of public attention. The *Herald of Free Enterprise* capsized outside Zeebrugge harbour. The ship had sailed with its bow doors open allowing the sea to swamp the car deck, resulting in 154 passengers and 38 crew being killed. The company *P&O European Ferries (Dover) Ltd*, was charged with corporate manslaughter, but the case was dismissed. In the second 1987 tragedy, 31 people died and 60 were injured when fire engulfed Kings Cross underground station. The cause was attributed to a discarded cigarette igniting waste that had accumulated under the escalators. The following year, there were again two major tragedies. The Clapham train crash, which killed 37 and injured 500 people, resulted from two trains colliding outside Clapham railway station. In the same year, an explosion destroyed the *Piper Alpha* oil
platform causing the deaths of 165 crew members. This was caused by a failure in the safety management system and lack of management procedures. In 1989 there were three tragedies: the Purley train crash caused the deaths of 5 and injures to 88 passengers when a train driver ignored a red light and crashed into the back of another train; The dredger 'Bowbelle' collision with the River Thames pleasure craft the 'Marchioness' caused the deaths of 51 and injures to 80 passengers, and the Hillsborough football stadium disaster caused the deaths of 95, and injuries to hundreds of spectators after a large number of people were allowed to enter the stadium at one time, in an uncontrolled manner. Of all these major disasters only the Herald of Free Enterprise case was progressed to a corporate manslaughter prosecution and that was dismissed (Wells, 1994b).

2.2 LYME BAY CANOE TRAGEDY - PETER KITE

The first conviction in English legal history of a company for Corporate Manslaughter took place in 1994; R v. OLL Ltd and Peter Bayliss Kite, more commonly known as the Lyme Bay Canoe tragedy (Knight, 1994). The incident involved a group of sixth form students from the Southway Comprehensive school in Plymouth, who were participants in an activity holiday at the St Albans Challenge Centre at Lyme Regis. Canoeing was among the range of activities that were available to the students and, as part of the introduction to the activity, the party was given a half hour basic instruction with canoes in the swimming pool. The following day members of the party decided what activities they wanted to do and eight pupils and one teacher decided to go canoeing. This group of novices was accompanied by two instructors, one male and one female, neither of whom were qualified to teach canoeing. Each participant was provided with a wet suit and life jacket, but no foot or head wear. The day's activity plan was basic and involved paddling from Lyme Regis to Charmouth and return, a journey to be undertaken at sea.

On 8 December 1994 Peter Kyte was found guilty of individual manslaughter and jailed for three years, which was reduced to two years on appeal. The case against the Lyme Bay centre manager Joe Stoddart was dropped when the jury failed to reach a verdict. The company, OLL Limited, was convicted of Corporate Manslaughter and
fined £60,000. It was the first corporate manslaughter conviction under English Law. A crucial aspect to this case was the fact that Kyte had personal knowledge of the safety failings. The failings were referred to by Mr Justice Ognall (Rees, 1994) who identified the letters sent to Kyte months before the tragedy by two competent instructors, who had left the Centre because they were concerned about safety. He told Kyte:

"what clearly separates this case from others is the notice you were given in chillingly clear terms of the risk you were running and potentially fatal consequences... Those dire forecasts became reality because of your complete failure to heed it and to act. I regret to say that to a degree you were more interested in sales than safety."

Peter Kite appealed against the sentence which was reduced from three year to two years imprisonment and the appeal is examined in Chapter three

2.3 JACKSON TRANSPORT - A. JACKSON CASE

Following the success of the 'Lyme Bay' case Jackson Transport (Ossett) Limited was convicted in 1996 of Corporate Manslaughter and fined £22,000.00. Its director Alan Jackson was convicted of individual manslaughter of one of his employees and jailed for 12 months and fined £1500.00. The case centred on 21 year old James Hodgson an employee of the company, who died less than an hour after being splashed with a deadly chemical, while cleaning the inside of a chemical tanker at Jackson Transport's base in West Ossett, Yorkshire. Mr Hodgson was carrying out the dangerous cleaning job protected only by a pair of overalls and a baseball cap. Special suits for protection against chemical risks were only provided to the tanker drivers of the vehicles, and the protective suits that were available on the company's premises were in poor condition. There were no hats, visors or goggles.

During the summing up of the case Judge Gerald Coles QC said (Jolliffe, 1996):

"If you did address your mind to the subject of safety clothing you failed to do so adequately. The fact that the deceased was not concerned to wear safety clothing
made it all the more important that you should have made sure that he not only had it, but that he wore it."

He further stated:

"I'm afraid you were at most, totally indifferent to your statutory duties...you failed to address your mind to any real system of safety and you failed to take precautions against inevitable disasters...the failure to provide a safe system of work was only the last in a long catalogue of deficiencies."

Apart from the failings outlined by the judge in the lack of personal protective equipment, there were no trained first aiders, nor was there first aid equipment provided by the company. There were no procedures to ensure safe entry to the tank or rescue equipment for use in an emergency. It was ironic that the failings were made worse in that the company had drawn up a manual detailing safe methods of cleaning out tankers. That manual had been produced six years before Hodgson's death and had been put in a drawer and forgotten. However the management had identified the hazards and associated risks and failed to implement a safe system of work (Jolliffe, 1996).

2.4 THE MARCHIONESS CASE

A case that evoked much publicity for Corporate Manslaughter was the sinking of the Marchioness, a Thames cruiser in August 1989. This incident raised the issue of public confidence as discussed in the Law Commission (1996e) report:

"The loss of 51 lives caused the captain of the dredger Bowbelle for not having a lookout. The vessels owners were not prosecuted. The captain was charged with the offence of failing to keep a proper lookout under Section 32 of the Merchant Shipping Act 1988, but the case was dropped after two juries failed to agree. A private prosecution for manslaughter was then mounted against the owners; but the Divisional Court stated that the Director of Public prosecutions might take over the proceedings and discontinue them or if it was too late to discontinue offer no evidence. It was thought that public confidence in industry and in enforcement..."
bodies suffered if the 'perpetrator' appeared to escape prosecution or conviction on a technicality rather that having his culpability tested in court by the same standards as that court would apply to a private individual on a charge of manslaughter."

Neither the DPP or CPS have progressed the case, therefore making it one of the focus cases of the authorities failing to administer justice through the courts.

2.5 THE PESCADO CASE

Another case of management failure involved the sinking of the trawler Pescado (Stokes, 1996). Joseph O'Connor a director of the company Guideday, and Alan Ayres an investor in the company, were charged with manslaughter and two charges of using forged instruments and documents knowing them to be false. However, the company was not charged with corporate manslaughter.

The basis of the case occurred when the fishing boat Pescado sailed from Falmouth on February 25 1991 to fish for scallops. The boat carried an untrained, non-competent crew of five men and one woman. While in the course of its business the boat foundered with the loss of all six crew members, and the boats operators Joseph O'Connor and Alan Ayres were charged with manslaughter. Joseph O'Connor, the managing operator was found guilty of manslaughter and jailed for three years, while Alan Ayres was acquitted.

Guideday Limited owned the boat. The managing director Alan Ayres while the 'controlling mind' of the company, had no knowledge of vessel operations. O'Connor provided the fishing experience and was the managing agent, and he knew what the safety regulations required but deliberately avoided complying with them. The defendants sent the Pescado and its inadequate crew to carry out a dangerous form of fishing in an unstable and unseaworthy sea vessel.

Key safety failings in the Pescado case were that the boat did not have a safety certificate, had inadequate equipment and means of alerting the rescue services. It was also claimed that the boat breached a number of safety regulations, including
only having one life raft instead of two. The life raft was provided by O'Connor from his garden having scraped the moss off it, before lashing it to the railings of the boat. There was no emergency positioning beacon, the compass did not work properly, nor did the autopilot and navigation lights and the boat had encountered engine problems on the previous voyage. The situation was so serious in respect to safety failings that a qualified skipper and two crew members had earlier refused to sail on the boat because it was dangerous, unstable, unseaworthy and dangerous and in fact not fit to go to sea. The final statement went to the judge who in passing sentence (Staples, 1996) said,

"That is, that by your gross negligence one member of the Pescado lost his or her life and it is on that basis that I sentence you."

The Pescado clearly shows a deliberate failing in any form of safety management and while the outcome of the case was positive, it could be argued that there was a case for corporate manslaughter. Charging a company with the offence of corporate manslaughter had has a difficult time in becoming established because of the definition of the crime of manslaughter. It was in 1987 that the decision of a coroner (who had held that a corporation could not be indicted for manslaughter) was challenged in an application for judicial review. The issue was not fully argued, but Bingham (Law Commission, 1996f) saw no reason in principle why such a charge could not be established and ‘was tentatively of the opinion’ that an indictment would lie.

The same question was argued in depth in 1990 for the case against P&O European Ferries (Dover) Ltd. In that case Turner (Law Commission, 1996g) thoroughly reviewed the authorities (including some in other jurisdictions) and came to the conclusion that an indictment for manslaughter would lie today against a corporation.

Turner noted that in the Birmingham and Gloucester Railway Co and Great North of England Railway Co cases, while it had been established that an indictment could lie against a corporation, it was said that a corporation could not be indicated for any offence involving personal violence. This was based on the grounds that a
corporation had no social duties, it could not suffer from a 'corrupt mind', as natural persons could. This was identified in the case of Cory Bros & Co, where Finlay (Law Commission, 1996h) felt bound by the authorities to hold that:

"an indictment will not lie against a corporation either for a felony or a misdemeanor involving violence, on the ground that mens rea could not be present in the case of an artificial entity like a corporation."

Turner (Law Commission, 1996i) rejected the arguments that these understandings of the law demonstrated that a corporation could not be indicted for manslaughter. He considered in detail the subsequent authorities that had introduced and developed the principle of 'identification'. It was this principal that had transformed corporate liability because it 'identified' the corporation with the state of mind and actions of one of its controlling officers, and it became possible to impute mens rea to a corporation and so to convict it of an offence requiring a mental element.

2.4 HERALD OF FREE ENTERPRISE CASE

The corporate manslaughter case of the capsizing of the M.V. Herald of Free Enterprise in the Report of the Court No 8074, Department of Transport (The Sheen Report, 1987a) has been reviewed to provide the facts of this important case.

The Herald of Free Enterprise was built for the Dover-Calais run and incorporated very powerful engines, capable of rapid acceleration, to enable the crossing to be made at high speed. The concept of the vessel and her sister vessels was to be able to disembark their passengers and vehicles rapidly and then without any delay embark passengers and vehicles for the return voyage. On the Dover-Calais run, these ships are manned by a complement of a Master, two Chief Officers and a Second Officer. The officers were required to work a 12 hours on duty shift and have not less than 24 hours off duty. In reality each crew was on board the vessel for 24 hours and then had 48 hours ashore.
On the 6th March 1997 the Roll on/Roll off passenger and freight ferry *Herald of Free Enterprise* under the command of Captain David Lewry sailed from Number 12 berth in the inner harbour at Zeebrugge. The ship was manned by a crew of 80 hands and was laden with 81 cars, 47 freight vehicles and three other vehicles. Approximately 459 passengers had embarked for the voyage to Dover. There was prevailing good weather with a light easterly breeze and very little sea or swell. The *Herald* passed the outer mole at 18.24 and capsized about 4 minutes later. During the final moments the *Herald* turned rapidly to starboard and was prevented from sinking totally by reason that her port side rested on the bottom in shallow water. Water rapidly filled the ship below the surface level with the result that 150 passengers and 38 members of the crew lost their lives and many others were injured.

The immediate cause of the disaster occurred because the ship went to sea with her inner and outer bow doors open. The assistant bosun accepted that it was his duty to close the bow doors at the time of departure from Zeebrugge and that he failed to undertake this duty. He had opened the bow doors on arrival in Zeebrugge and was engaged in supervising members of the crew in maintenance and cleaning the ship until he was released from work by the bosun. He then went to his cabin, where he fell asleep and was not awakened by the call 'Harbour Stations', which was given over the Tannoy address system. He remained asleep on his bunk until thrown out of it when the *Herald* began to capsize.

The Captain or Master of the *Herald* on the 6th March 1987 was responsible for the safety of his ship and every person on board, and he took the *Herald* to sea with the bow doors fully open. The result was the tragic consequences and therefore he must accept personal responsibility for the loss of his ship. The full burden of the duty falls to the Master to ensure that his ship is in all respects ready for sea. The report highlights a number of points of mitigation that were made on his behalf, of which the three principal ones were as quoted. First, the Master merely followed a system which was operated by all the masters of the *Herald* and approved by the Senior Master. Second, the court was reminded that the orders entitled *Ship's standing orders* issued by the Company make no reference, as they should have done, to opening and closing the bow and stern doors. Third, before this disaster there had
been no less than five occasions when one of the company's ships had proceeded to sea with bow or stern doors open. Some of those incidents were known to the management, who had not drawn them to the attention of the other Masters. The Master told the Court that if he had been made aware of any of those incidents, he would have instituted a new system under which he would have required that the doors were closed.

This is clear evidence of a failure in the management system, where managers with full knowledge, ignored a perceived risk and placed both crew and passengers at risk. One of the five masters who took it in turn to command the *Herald* was the Senior Master, and one of the functions as Senior Master was to act as a co-ordinator between all the masters and officers of the ship, in order to achieve uniformity in the practices operated by the different crews.

From the brief facts surrounding the disaster it is seen that the errors or omissions on the part of the Master, the Chief Officer, the assistant bosun, and the failure of the Senior Master combined to be the root cause. However, a full investigation into all the circumstances of the disaster determined that faults lay higher up in the Company, in that for some unknown reason the Board of Directors did not appreciate their responsibilities for the safe management of their ships. In fact, all concerned in management, from the members of the Board of Directors down to the junior superintendents, were guilty of fault in that they must be regarded as sharing responsibility for the failure of management. The report quotes (Sheen, 1987b) that:-

"from top to bottom the body corporate was infected with the disease of sloppiness.....The failure on the part of the shore management to give proper and clear directions was a contributory cause of the disaster....."

Based upon the evidence of the case, the Director of Public Prosecutions instituted a Corporate Manslaughter prosecution. It was also considered that while the company was charged with manslaughter any legal actions should reach every person, whatever their employment status, and so two representatives of senior management, the
assistant Bosun, the Bosun, the Chief Officer, and the two Captains were charged with manslaughter.

2.5 PROSECUTION FOR MANSLAUGHTER

Under current English law the P&O European Ferries (Dover) Ltd prosecution was a landmark case in corporate liability for manslaughter, but the process has been and still is a torturous and ad hoc system. A case proposed for manslaughter can be identified by the Health and Safety Executive, a Coroner or the Police, who submit details of the case to the Crown Prosecution Service (CPS). The CPS then reviews the evidence and determines whether to proceed or not, and that decision is founded on the likelihood of a conviction and whether a prosecution is in the public interest. An example of one such case is described by Balain (1995) in an article entitled Juries, the CPS and Unlawful Killing:

"A coroner's court found that workers who were killed in the course of their employment had been unlawfully killed but a manslaughter prosecution appeared unlikely. The case has already been considered by the Crown Prosecution Service, (CPS) who, based upon their assessment that there was insufficient evidence, declined to prosecute. The coroner, as a matter of course referred the case back to the CPS but as the commentator identifies, history indicates that unless new evidence is produced the CPS will take no further action. The accident happened during the refurbishment of a shop, where the partial demolition of a wall on the first floor of a three story premises was carried out as people worked in a shop below. It appears that a supporting wall was demolished without sufficient alternative support being in place. Two people were killed in the ensuing collapse. The two persons killed were not trained construction workers, but were working until something better came along".

For a prosecution to be successful under the current English law it has to be proved that a company was reckless to the risk of death or injury from its activities, such that company can be convicted of manslaughter. Fink (1996) identifies that because a company does not possess a 'mind', the courts have required there to have been
recklessness by one or more of the company's directors or senior managers. That person/s will have to be proved to have represented the 'mind and will' of the company at the time of death. It is the requirement to identify an individual with control, within the company, who has shown recklessness that has been the stumbling block for corporate manslaughter cases. The exception to this has been Kite - OLL, and Jackson - Jackson Transport, and that has provided some evidence that the size of the defendant company may be a major factor. Both OLL and Jackson Transport were small companies and the directors were actively involved in the company's day to day operations. It was therefore easy for the prosecution to identify the 'controlling mind' and prove recklessness.

In addition to the failure to obtain a successful prosecution for manslaughter against large corporations and the easier option with small companies often termed 'one man bands', there was the successful prosecution of a landlord and a gas fitter for manslaughter, which identifies individuals as causing death through work rather than companies (Anon, 1998).

However, Fink (1996) states that while the prosecutions of OLL and Jackson Transport were successful they did not open the way for the prosecution of larger companies where the directors or senior members of the organisation are removed from the day to day 'shop floor' activities and systems of work. In an effort to redress what is considered by the Law Commission to be an imbalance in the justice system a new offence of Corporate Killing is proposed.

Manslaughter at work is a topic of increasing public interest and in the wake of some of the major disasters there has been the formation of action groups such as Disaster Action, Herald Families Association, Marchioness Action Group and other established organisations such as Victim Support, the Royal Society for the Prevention of Accidents and the Trade Union Congress (Law Commission, 1996) These groups, along with others, are seeking redress against the controlling minds of companies, such as directors and senior management, and provide the power lobby for the proposed offence of Corporate Killing.
Slapper (1992) identifies the issue of public unrest in the current failures in the law of Corporate Manslaughter in an article in which he states;

"In January, the Piper Alpha Families and Survivors association discontinued their attempt to execute a private prosecution of manslaughter against the oil company Occidental. They were ultimately thwarted by a number of legal obstacles stemming from the fact that since the disaster in 1998, when 167 people died, the company has been sold and changed its name and there have been several significant changes in key personnel. Ivor Glogg, who lost his wife in the Marchioness disaster in August 1989, is bringing a private prosecution against South Coast Shipping Company Ltd of Canute, Southampton, owners of the Bowbelle and the four senior managers. In February, committal proceedings were adjourned for the third time in this case pending judicial review being instituted by the defendants. This case could become only the third trial ever involving a charge of corporate manslaughter but Mr Glogg, who has already spent £20,000 on this matter, has a difficult battle ahead of him as he confronts a corporate defendant which is a subsidiary of the public company Ready Mix Concrete. When an engagement of this sort becomes a war of attrition those who face corporate defendants are plainly prejudiced."

Further evidence of concern about the failing of Corporate Manslaughter is shown in an article in Occupational Health (Anon 1994) which states;

"In a recent letter to Phillip Oppenheim, minister for the Department of the Environment, Allan Black, the national officer for construction workers, commented on British Rail and Tilbury Douglas being fined only £25,000 for failing to meet safety standards which led to the death of two building workers......The letter said, 'This example is encouraging a laissez faire attitude to the health and safety of workers. Non-compliance with existing laws is allowing companies to get away with legalised manslaughter....Failure to force companies to comply with existing legislation....petty fines on large corporations leaves employers with a greater freedom to kill...."

Howard (1992) reviews the subject of Corporate Manslaughter and poses the question 'why corporate liability?'
There are some important arguments in favour of companies being prosecuted for corporate manslaughter. Fixing corporate liability is, in some cases, easier than prosecuting individual directors where there may be difficulty in determining which individuals are liable. Corporate liability ensures that the crime will not go unpunished and that a fine in proportion to the gravity of the offence may be imposed when it might be out of the means of the individuals concerned. Since the names of the officers will mean little to the general public, only a conviction of the corporation itself will serve to warn the public of the wrongful act which has been committed in its name.

2.6 MANSLAUGHTER FAILURE RULING

The dramatic headlines 'judge attacks Government for failure to bring in law of Corporate killing' - 'No one can be tried over this carnage', were the opening lines of a report by Twomey (1999) reporting on the Corporate Manslaughter trial of Great Western Trains. The report stated:

"A judge launched a stinging attack on the Government yesterday (Friday 23 July 1999) as he threw out manslaughter charges against a rail company accused over the deaths of seven passengers".

The case of Great Western Trains Ltd (Towmey 1999) involved the 10.32 Swansea to London Paddington train which was driven by Larry Harrison. The train was an Inter City 125 which passed through a red signal at 125 mph and crashed into a freight train near Southall station in West London. The train was fitted with two safety devices, which could have prevented the incident, but neither was working. As a result the company was charged with Corporate Manslaughter and the train driver with individual manslaughter. It was anticipated that the managing director of GWT, Richard George, would be personally charged with manslaughter because of his responsibilities to ensure trains follow adequate safety procedures. The train driver had looked down to pack his bag and therefore not seen the red signal. The case against him was dropped because it was said that the crash had left him psychologically unfit to face trial. That case for the Crown failed because it failed to
identify a senior figure within GWT who was the ‘directing mind and will’ and who failed to ensure the safety of the passengers.

This was a landmark case and focused on the prosecution of Great Western Trains Ltd for Corporate Manslaughter which was terminated by the Old Bailey judge, Mr Justice Scott Baker. Twomey (1999) reported the judges comments:

"The Old Bailey judge rebuked ministers for failing to act on the recommendations of the Law Commission three years ago to introduce a new offence of Corporate Killing."

The impact of this ruling for the future of Corporate Manslaughter prosecutions means that no large organisation can ever be prosecuted for corporate manslaughter unless there is a radical change in the law. Twomey (1999) continued to state that:

"Attorney General John Morris is to appeal against the findings....The case against the company foundered on an age old principle.....For the prosecution to succeed, the Crown had to identify a senior figure within GWT who was the ‘directing mind and will’ and who failed to ensure the safety of the passengers’.

This again defines the basis of Corporate manslaughter failings which was clarified by the judge (Twomey 1999) who said;

"The only basis on which the prosecution may, in law, advance a case against Great Western Trains for manslaughter is by identifying some person within the company whose gross negligence was that of Great western Trains itself. The only candidate would be managing director Richard George, who was responsible for all matters of safety. In the absence of Mr George having procured, authorised or directed any tortious act, he cannot be guilty of manslaughter. Consequently, neither can Great Western Trains.........Were the law otherwise, a conviction would mark public abhorrence of a slipshod safety system leading to seven deaths and many injured victims”.

After the failure of the GWT Corporate Manslaughter case, the directors of Roy Bowles Transport were prosecuted for Corporate Manslaughter. While large
organisations escape the legal process for manslaughter at work, smaller companies are not affected by the Scott Baker ruling and continue to face corporate liability for deaths at work (Leathley 1999). A newspaper article stated that two directors were found guilty of Corporate Manslaughter. In fact the two directors of the company were found guilty of individual Manslaughter at the Old Bailey on the 19 November 1999.

The case centred on a driver employed by the company who had driven excessive hours when his articulated lorry crashed into the back of an empty skip lorry. The skip lorry careened across the central reservation where it landed on top of a car, which resulted in a seven car pile up, leaving two dead. The directors were accused of being "grossly negligent" in allowing their driver to spend more than 60 hours a week behind the wheel and breaking the law on driving hours. A report by Leathley (1999) on the hearing states:

"Stephen Bowles and his sister Julie were convicted of two charges of manslaughter, after the court was told that they knew, or should have known, that the driver, Andrew Cox, of Colnbrook, Buckinghamshire, was in a dangerously exhausted state".

Each director received a twelve month jail sentence, suspended for two years. The driver received a thirty month jail sentence. The guilty verdicts were considered a success but failed to deliver adequate verdicts (Harvey 1999).

The Bowles case identifies an issue that the two individuals were identified as the controlling minds and found guilty of manslaughter as individuals and sentenced.

There is therefore very powerful evidence that there is a requirement for an offence of Corporate Manslaughter to be introduced into the current legal system. This profile has been raised by John Prescott, the Deputy Prime Minister, in an interview with Harrison (1999) who states:

"New laws are to be brought in to punish companies responsible for fatal accidents such as the Marchioness riverboat disaster...........Mr Prescott said that new laws
would allow firms to be charged with corporate killing without the need to blame specific individuals. The legislation would be brought in as soon as possible following the 'fiasco' over the Marchioness. The Marchioness case has brought home to everybody the urgent need for new legislation on corporate killing. We are working on it now and it will be brought in as soon as possible. The victim's relatives need to know that everything possible has been done to give them justice.

This chapter has provided an overview of manslaughter and potential manslaughter cases while the next chapter will review the success and failings within the current law of manslaughter, which has an imbalance between a small 'one man' company and a large corporation.
CHAPTER 3 - THE BASIS OF CORPORATE MANSLAUGHTER

In the previous Chapter, a number of corporate manslaughter cases were reviewed as well as a number of cases that involved loss of life but were not prosecuted for corporate offences. This chapter reviews the failures and successes of two of the most significant cases where corporate manslaughter offences were laid. One was successful in obtaining a conviction, but the other case was dismissed at an early stage in the trial. They provide the foundations on which under the current English law corporate manslaughter can be progressed. While corporate liability is an option, there still needs to a person 'identified' with the act that causes death, and it is the 'identification' that poses a hurdle to a corporate manslaughter prosecution.

Placing blame onto a corporation creates the situation where every act or omission of an individual that the company employs is attributed to the company itself. It is an issue raised by Clarkson (1996) where it is stated:

‘Any organisational faults in a company’s operations must be derivative of human activity. For example, Susan Wolf argues, by analogy with sociopaths who lack emotional understanding and consciences, and therefore are not regarded as wholly morally responsible agents, that organisations cannot be morally responsible because they too lack emotional capacities and therefore criminal liability is inappropriate. In her words, ‘they lack the unified consciousness necessary for feeling. To put it differently, organisations lack souls.’ She goes on to conclude, however, that organisations can be practically responsible because they have the capacity to be guided by moral goals and constraints and, if they fail to do so, should be made liable for paying for the consequences, that is civil liability only.’
This could mean that an undertaking which had no knowledge or control over an event, could be convicted. This situation may be overcome if the option of 'controlling minds' is adopted. This is based upon the view that the 'minds and will' of the directors and managers of an undertaking are the 'mind and will' of the undertaking itself. The outcome of this is that where an offence is committed by a director or manager of a company, then the company itself is deemed to have committed it.

There are complications in trying to identify corporate liability as described by Milne (1999) in the case of Simon Jones.

"Mr Jones was employed by Personnel Selection, an employment agency, who sent him to the company Euromin to undertake work in Shoreham Docks. His employment was that of a stevedore, unloading cobble stones from a Polish ship. He had no training or supervision, and the company Eurmin was reported as breaking a string of health and safety regulations. A crane fitted with a two-tonne grabb was used and Mr Jones was killed by the grabb when his head was crushed and partially severed. The general manager and crane driver were arrested by the police, but were released without charge. The Department of Trade and Industry has decided that there was not enough evidence to take any action against the agency, and the Crown Prosecution Service decided not to charge Euromin or its general manager with manslaughter because of insufficient evidence. Solicitor, Louise Christian voiced what is becoming a common view in that it is not a problem with evidence, but of political will, as the authorities do not like prosecuting senior business directors."

In 1987 a coroner decided that a corporation could be indicted for manslaughter, a decision that was challenged in an application for judicial review. Bingham (1989) found no reason why such a charge could not be laid and was;

"...tentatively of the opinion that on appropriate facts the mens rea required for manslaughter can be established against a corporation...it is important to bear in mind an important distinction. A company may be vicariously liable for negligent acts and omissions of its servants and agents, but for a company to be criminally liable for
manslaughter...it is required that the mens rea and actus reus of manslaughter should be established not against those who acted for or in the name of the company but against those who were to be identified as the embodiment of the company itself.”

In 1990 the same question arose in P & O European Ferries (Dover) Ltd when Turner reviewed the authorities. He rejected the argument that a corporation could not be indicted for manslaughter. He considered that the ‘identification’ process linked the corporation with the ‘minds and actions’ of one or more of its ‘controlling’ officers. This meant that it was possible to establish mens rea for a corporation and thus be able to convict it of an offence requiring a mental element. He summarised (Turner, 1991) by stating;

“Since the nineteenth century there has been a huge increase in the numbers and activities of corporations...A clear case can be made for imputing to such corporations social duties including the duty not to offend all relevant parts of the criminal law. By tracing the history of cases decided by the English Courts over the period of the last 150 years, it can be seen how first tentatively and finally confidently the Courts have been able to ascribe to corporations a ‘mind’ which is generally one of those essential ingredients of common law and statutory offences....Once a state of mind could be effectively attributed to a corporation, all that remained was to determine the means by which that state of mind could be ascertained and imputed to a non natural person. That done, the obstacle to the acceptance of general criminal liability of a corporation was overcome....[T]here is nothing essentially incongruous in the notion that a corporation should be guilty of the offence of unlawful killing....[W]here a corporation, through the controlling mind of one of its agents, does an act which fulfils the prerequisites of the crime of manslaughter, it is properly indictable for the crime of manslaughter.”

The concept is further explained by Denning (1957) who stated;

“A company can in many ways be likened to a human body. It has a brain and nerve centre which controls what it does. It also has hands which hold the tools and act in accordance with directions from the centre. Some of the people in the company are mere servants and agents who are nothing more than hands to do the work and cannot be said to represent the mind and will. Others are directors and managers who
represent the mind and will of the company, and control what it does. The state of mind of these managers is the state of mind of the company and is treated as such by the law.”

The ‘identification’ principle is laid down in Tesco v Nattrass (1972) which distinguishes between those members of a company that qualify as its ‘controlling minds’ and those that do not. The main reason for this is that the principle requires the prosecution to identify one or more ‘controlling minds’ who are themselves guilty of a manslaughter offence. The distinction drawn in the Tesco case between things done by the management and the organisation of the company, and things done at purely operational level on the other, appears to encapsulate the nature of the distinction that needs to be drawn.

Lord Reid (1972a) in Tesco Supermarkets v Nattras said;

“[A corporation] must act through living persons, though not always one or the same person. Then the person who acts is not speaking or acting for the company. He is acting as the company and his mind which directs his acts is the mind of the company. There is no question of the company being vicariously liable..... He is an embodiment of the company.......and his mind is the mind of the company. If it is a guilty mind then that guilt is the guilt of the company.”

An interesting point is posed by Wells (1997) who raises the question;

“Should corporations be liable because of their own wrongdoing or because they are in a better position to control (or be seen as responsible for) the wrongdoing of others ?......As a liable ‘vicarious’ usually connotes liability for offences of strict liability committed by a person’s agent or employee; ‘direct’ connotes liability of a corporation for offences committed by someone within the company who is a directing mind.”

The ‘directing minds’ of a corporation are considered to be those who are at the centre of its being, who are its controlling officers, those in higher management as opposed to those in relatively subordinate posts. This is emphasised by Lord Reid (1972b) in Tesco Supermarkets v Nattrass who said;
"The board of directors, the managing director and perhaps other superior officers [who] carry out the functions of management and speak and act as the company...."

The status of the person who can be 'identified' as the 'controlling mind' must also be considered and is the issue raised in R v Rozeik where Leggat (1996) said;

"Whether or not a company is fixed with the knowledge acquired by an employee or officer will depend on the circumstances. It is necessary first to identify whether the individual in question has the requisite status and authority in relation to the particular act or omission in point....It follows from this that information given to a particular employee, however senior, may not be attributed to the company if that employee is not empowered to act in relation to the particular transaction. An employee who acts for the company within the scope of his employment will usually bind the company since he is the company for the purpose of the transaction."

It is evident that not every person who is part of a corporation or employed by it, can be a 'controlling mind' in the overall sense, but can act for the corporation as part of designated duties. According to Swanwick (1968) in R v Andrews Weatherfoil Ltd (1968) the Court of Appeal stated that;

"not every responsible agent, high executive or manager of a department was a 'directing mind' of the company."

3.1 MANAGEMENT FAILURE IN A SMALL COMPANY - LYME BAY CANOE TRAGEDY - PETER KITE

The first conviction in English legal history of a company for Corporate Manslaughter took place in 1994; R v. OLL Ltd and Peter Bayliss Kite, more commonly known as the Lyme Bay Canoe Tragedy (Knight, 1994). The incident involved a group of sixth former students from the Southway Comprehensive school in Plymouth who were participants in an activity holiday at the St Albans Challenge Centre at Lyme Regis. Canoeing was among the range of activities that were available to the students and, as
part of the introduction to the activity, the party was given a half hour basic instruction with canoes in the swimming pool. The following day members of the party decided what activities they wanted to do and eight pupils and one teacher decided to go canoeing. This group of novices were accompanied by two instructors, one male and one female, neither of whom were qualified to teach canoeing. Each participant was provided with a wet suit and life jacket, but no foot or head wear. The day’s activity plan was basic and involved paddling from Lyme Regis to Charmouth and return, a journey to be undertaken at sea.

At about 10 am the party set off and soon encountered problems. One of the student’s canoes capsized and it required the male instructor to right the craft and help the student back into it. The teacher then capsized and required the male instructor to assist in recovery of the canoe and help the teacher back into the canoe. During this incident, the female instructor directed the others to ‘raft up’ in a line, so making a more controlled and stable group. However, the group was drifting out to sea and the wind had increased causing the waves to get bigger, all adding to the students’ problems. They then became seasick which in turn caused distress, and added to the very evident concern as to their situation. While they did what they could to help one another, the problems developed rapidly with canoes capsizing and depositing the students in the cold water, clinging to the upturned craft.

The group were in serious trouble and because of a management failure, they had no method of raising the alarm (Midgley, 1994). Nobody onshore was aware of any possible problems and so the hours passed with the youngsters in the water, cold, tired and distressed. In an act of desperation two students decided to swim to shore and as events unfolded were the last to be rescued. The male instructor and teacher were located some eight miles down the coast, having been in the sea for seven hours. The main group were rescued two and a half miles from the nearest coast. The final outcome was that four of the youngsters died as a result of the tragedy.

Mr Peter Kyte, the managing director of Active Learning and Leisure Ltd, the operators of the centre, had failed to ensure the safety of the group. He had been
notified in writing by previous employees of the failings in safety procedures and
equipment. The ill-fated group had gone to sea, with very limited instruction,
unqualified instructors, no flares for alerting the Coast guard, no emergency plan and
no support boat. The students had not been taught how to work their lifejackets nor
were they told to inflate them when they were in the water. The situation was
compounded when the group failed to return, and the management delayed in alerting
the rescue services.

Some key issues raised during the trial focused on the failings. The Times newspaper
carried the headline Death Trip Canoe Instructors Had No Safety Training. The
article (Knight, 1994) stated:

"The instructor who led the canoeing expedition from Lyme Bay in which four
teenagers died admitted yesterday that he had no information about local weather
conditions, the tide or currents on the day of the trip...Mr Mann (instructor) said he
had received no instruction to carry his concern to Joseph Stoddart, manager of Lyme
Regis Challenge Centre. The students were not issued with spray decks. It had
caused me concern because of the switch from double kayaks to single. With them
sitting lower in the water, there was obviously more chance of water entering."

In the appeal issues were raised by the defence in respect to mitigation in
manslaughter at work cases. The details of the conviction are quoted (Sweet and
Maxwell, 1996a) as follows;

"On December 8, 1994, in the Crown Court at Winchester before Ognaill J., after a
trial lasting three weeks, Peter Kite was convicted by a majority verdict on four counts
of manslaughter and sentenced to three years imprisonment on each count
concurrently. He appeals against those convictions by leave of the single judge. His
appeal against sentence was referred to the Full Court. It is important to recite the
terms of the indictment as laid against the appellant. The charge was one of
manslaughter, and the particulars of the alleged unlawful killings were the same in
each count, namely that on March 22, 1993 Peter Kite unlawfully killed the named
person in that:
“(a) As the Managing Director of OLL Limited, owed a duty of care to those who took part in the outdoor leisure activities operated by OLL to take reasonable care for their safety;

(b) In breach of that duty he failed to take reasonable care for the safety of [the deceased], by;

   (i) failing to devise, institute, enforce and maintain a safe system for the execution of an outdoor leisure activity, namely canoeing, by students attending the St Alban’s Centre, Lyme Regis, Dorset;......

   (iv) failing to heed, either any or all, the content of an undated letter sent to OLL by Pamela Joy Cawthorne and Richard Retallick in or about late June 1992;

   (v) failing to supervise the Manager of the Centre (namely Joseph Thomas Stoddart) so as to ensure that canoeing was being safely taught at the Centre;

(c) His aforesaid breach of duty amounted to gross negligence on his part, and;

(d) His aforesaid negligence was a substantial cause of the death of [the deceased]”

In the indictment as originally laid, and as presented to the jury, there were two further particulars of breach of duty, (Sweet and Maxwell, 1996b) namely:

“(ii) failing to procure the employment by OLL at the Centre of an adequate number of staff, suitably qualified to give safe instruction of canoeing;.....”

“(iii) failing to procure the provision by OLL at the Centre of all equipment necessary for safe instruction of canoeing;.....”

Those two further allegations were, in the course of the trial, abandoned by the Crown, and Mr Lawson submits that the abandonment of those two allegations is
significant in particular in that the evidence showed that his client, Mr Kite, had in fact complied, rather than failed to comply, in respect of those matters.

The details of the gross negligence case against Mr Kite were based on the absence of a safe system of operating at the Centre, for failing to take notice of the letter from former employees, who made complaints about the absence of safety, and his failure to adequately supervise the manager. The report raises an important issue when it states that Kite was not directly responsible for the canoeing activities that formed the fatal incident that occurred on March 22, 1993. That was the allegation made by the Crown against Stoddart, who was jointly indicted. However, the jury disagreed, and the Crown elected not to proceed with the case against him.

The company known as "Active Learning and Leisure Limited" who operated a leisure centre at St Alban's Centre in Lyme Regis was also indicted with corporate manslaughter and subsequently convicted. The corporate structure was such that Mr Kite was the Managing Director, and Mr Stoddart was the Manager.

The company was a one man operation and so the 'directing mind' was that of its managing director, and the company's liability came from the 'directing mind' having formed the mens rea. In the case Ognall (1994) said;

"A word about the position of the company. You have been correctly told that what must be proved against the company is precisely what must be proved against Mr Kite. A company can only act and be criminally responsible through its officers or those in a position of real responsibility in conducting the company's affairs. It is usually put this way. It is proved that some person or persons who were the 'controlling minds' of the company were themselves in this case guilty of manslaughter? If the answer to that question is a sure 'Yes', then the company is likewise guilty."

The Crown alleged that Kite, as the Managing Director of OLL Ltd had the primary responsibility for devising, instituting, enforcing and maintaining an appropriate safety policy, and was therefore responsible for the safety standards at the Centre.
which were found to be deficient. It was said that the defendants had breached
guidelines issued by the British Canoe Union.

Reliance during the case was placed on a brochure published by OLL Ltd and it was
submitted that the judge did not give the jury the guidance that they could expect in
relation to the relevance of the brochure. The Crown also relied on the letter written
by Miss Cawthorne and Mr Retallick, previous instructors with OLL Ltd, and the facts
of that letter are quoted in part from the report (Sweet and Maxwell, 1996c):

“At present we are walking a very fine line between 'getting away with it' and having
a very serious incident....We would also like to know why we do not get supplied
with a first-aid kit and tow-line.....It's unsafe and not organised.....having seen your
1993 brochure and planned expansion, we think you should have a very careful look
at your standards of safety, otherwise you might find yourselves trying to explain why
someone's son or daughter will not be coming home. Nobody wishes or wants that to
happen, but it will sooner or later.”

It was Mr Kite's case, through his evidence that he took that letter seriously, and had
acted upon the contents. The report states that Mr Lawson submitted that the letter
was written in 1992 and, consequently, it might not provide very useful evidence as to
the situation as it was in March 1993. In fact it could be argued that it would be very
good evidence because if notice had been taken and the concerns actioned, then a safe
system of working would have been in place. Mr Lawson identified in the evidence,
that Mr Kite had made considerable efforts to comply with the complaints that were
raised, and that substantial changes had taken place. It again could be argued that the
changes were not suitable and sufficient, particularly based upon the evidence that
convicted Mr Kite.

In addition to those matters the Crown alleged that Mr Kite had failed to supervise Mr
Stoddart which, because he was the 'controlling mind' of the company, he was
expected to do so. Expert evidence was called by the Crown, and a number of
criticisms were made including, in particular, the lack of experience and suitability of
Mr Mann and Miss Gardner as instructors to lead the canoeing expedition.
The report (Sweet and Maxwell, 1996d) states that Mr Kite gave evidence on his own behalf and stated that:

"He was responsible for overall policy and money matters, but left the actual day to day operational running of the Centre to the Manager, Mr Stoddart."

He further stated (Sweet and Maxwell, 1996e) that:

"he had absolutely no knowledge that novices were taking part in sea activities, and was horrified when he heard that they were and that this accident had occurred. This evidence, and what emulates from it, was central to the submissions of this appeal. Mr Kite stated that he had immediately taken steps in relation to the Cawthorne letter and had fulfilled his duties in so far as he could in relation to safety precautions."

The appeal against conviction was dismissed. Court proceedings involving health and safety failings generally cause great difficulties because the court has to make a balanced judgement between two extreme positions. There is the situation when people have been killed through a workplace accident. In particular when the lives of young people have been lost, it is very natural for the families of the deceased to take the view that no sentence can be too long in the light of what has happened. In opposition there is an individual who has been convicted of offences, where he had no 'criminal intent', who will not readily understand why he has been sent to prison.

There was never any suggestion that Mr Kite was directly responsible for what occurred on March 22, 1993 because he was not present, but it was his failure to proved a suitable health and safety system. When the judge (Sweet and Maxwell, 1996f) passed sentence he said:

"Beyond doubt these matters are so serious as to demand a sentence of immediate custody, and of some substance."
While the fact that a term of imprisonment was imposed was not in question, what was in question, and the subject of the appeal, was whether in all the circumstances of this case, a sentence of three years imprisonment was too long.

The final summing up of the appeal court (Sweet and Maxwell, 1996g) stated the following:

"Mr Kite is now aged 46 and is a man of previously impeccable character. Any prison sentence imposed on a man in those circumstances is, of course, devastating to him. Nonetheless, as we have said, the facts quite clearly demanded a substantial sentence. Taking those matters of a personal nature, together with the facts as proved, we have been persuaded that the sentence imposed by the learned judge was too long. We propose to substitute for the sentence of three years imprisonment one of two years imprisonment on each count to run concurrently."

Criminal intent is a fundamental issue in health and safety cases. The Health and Safety at Work etc Act 1974 (HMSO, 1974) requires every employer to ensure the health and safety of those in his employment and those not in his employment but who could be affected by his activities. The Management of Health and Safety at Work Regulations Approved Code of Practice (HSE, 1999) defines more explicitly the requirements of managing health and safety. If an individual or corporation disregards the prescribed Legislation and Approved Code of Practice, then it could be described as intentional and therefore be a criminal act, albeit not in the normal publicly accepted criminal content. It is the task of the court and in particular the jury to determine whether a particular case is one of gross negligence and that is what is often the most difficult. In this case the jury came to the conclusion that Mr Kite's conduct was that of gross negligence and found that he was criminally liable, and he was convicted on the basis of his negligence.
3.2 MANAGEMENT FAILURE IN A LARGE COMPANY - P&O EUROPEAN FERRIES (DOVER) LTD

The corporate manslaughter prosecution following the capsizing of the *M.V. Herald of Free Enterprise* in the Report of the Court No 8074, Department of Transport (The Sheen Report, 1987) has been reviewed to provide the facts of this important case.

The *Herald of Free Enterprise* had been transferred to the Dover to Zeebrugge route (Sheen, 1987a) where the passage takes 4½ hours, and because it is a longer journey than that of the Dover to Calais route, it gives the officers more time to relax. On this basis the company only employed a Master and two deck officers which they were quite entitled to do, providing proper thought had been given to the organisation of the officers' duties and the safety of all those onboard. The report states (Sheen, 1987b) that at Zeebrugge, the turn-round was different from the turn-round at Calais in four main respects.

“At Zeebrugge, (1) only two deck officers were available, (2) only one deck could be loaded at a time, (3) it was frequently necessary to trim the ship by the head, and (4) the bow doors could be closed at the berth. It was because of these differences that no real thought was given to the organisation of the duties of the officers, which meant that immediately loading was complete the Chief Officer considered himself under pressure to leave the loading deck to go to his harbour station on the bridge.”

The report identifies that there were three crews and five sets of officers for the manning of the *Herald* on this route, and that meant that the officers did not always have the same crew. This is a failing in the operating system because as the report (Sheen, 1987c) states:

“a competent superintendent, applying his mind to the organisation of the officers and crew, would have issued 'Company Standing Orders', which would have been uniform for all the ships of one class........they would have covered all aspects of organisation, not only for the Calais run but also for the Zeebrugge run when the ship carried only two deck officers in addition to the Master........No company orders were issued; however, the Company had issued 'Ship's Standing Orders', and these
were in place in March 1987 but they highlight that there was a lack of proper organisation."

In July 1984 the company had issued a general instruction that defined that it was the duty of the officer loading the main vehicle deck to ensure that the bow doors were 'secure when leaving port'. Evidence was forthcoming that instruction had been regularly disregarded and had been viewed as meaning that it was the task of the loading officer only to see that someone was at the controls and ready to close the doors. That was not the management's intention through the instruction, which was not worded clearly, and as a consequence it was not followed. If the instruction had been clear and followed the disaster would not have occurred.

The operation of closing the doors could be completed in less than three minutes and it was not understood by the court as to why the loading officer could not remain on the car deck until the doors were closed and secure before going to his harbour station on the bridge. The evidence showed that it was the culture of the officers that they always felt under pressure to leave the berth immediately after the completion of loading. This culture spread to the officer on the car deck who would call the bridge and tell the quartermaster to give the order 'harbour stations' over the Tannoy, often before loading had been completed.

There were further conflicts in that if the Officer of the Watch was the loading officer it caused a conflict in his duties. This problem was brought to the attention of management by a memorandum dated 21st August 1982 (Sheen, 1987d) from the Senior Master of *FREE ENTERPRISE VIII* in which he said:-

"Departure from Port:

It is impractical for the O.O.W (either the Chief or Second Officer) to be on the Bridge 15 minutes before sailing time. Both are fully committed to loading the ship. At sailing time, the Chief Officer stands by the bow or stern door to see the ramp out and assure papers are on board etc. The Second Officer proceeds to his after mooring station to assure that the propellers are clear and report to the bridge."
This is further compounded by a damming internal memorandum dated 18th August 1986 (Sheen, 1987e) sent to assistant managers by the operations manager at Zeebrugge:

“There seems to be a general tendency of satisfaction if the ship has sailed two or three minutes early. Where, a full load is present, then every effort has to be made to sail the ship 15 minutes earlier.....I expect to read from now onwards, especially where FE8 is concerned, that the ship left 15 minutes early......put pressure on the first officer if you don’t think he is moving fast enough. Have your load ready when the vessel is in and marshall your staff and machines to work efficiently. Let’s put the record straight, sailing late out of Zeebrugge isn't on. It's 15 minutes early for us.”

The evidence that there was pressure on the deck officers was clear to the court even though the company stated, that the disaster could have been avoided if the Chief Officer had stayed on the car deck for another three minutes. The failure was that the company took no formal action to ensure that the Chief officer remained on the car deck until the bow doors were closed. The ‘Ship’s Standing Orders’ issued by the company made no reference, as to the operating of the bow and stern doors. The court was told that before the disaster there had been other occasions when one of the Company’s ships had sailed with bow or stern doors open. A crucial element in this case is that some of those incidents were known to the management, and they had not done anything about it.

The Chief Officer, relieved the second Officer as loading officer of G deck shortly before he instructed the quartermaster to call the crew to harbour stations. Accordingly, it then became the duty of the Chief officer to ensure that the bow doors were closed. He did not dispute the fact that this was his duty, but he interpreted the instruction laid down in July 1984 that it was the duty of the officer loading G deck to ensure that the assistant bosun was at the controls. Of all the many faults which combined to lead directly or indirectly to this tragic disaster, that of the Chief Officer was the most immediate.
While the management system which was in operation for all vessels was fundamentally flawed, it did not remove the personal responsibility of the captain for taking his ship to sea in an unsafe condition. By doing so he was seriously negligent in the carrying out of his duties and that negligence was one of the contributing causes of the accident. The report highlights an internal memorandum dated 22nd November 1986 (Sheen, 1987f) and addressed to the Chief Superintendent, and is quoted:-

"The existing system of Deck Officer manning for the 'Blue Riband Class', ship which relieves on the Zeebrugge run is unsatisfactory. When 'HERALD' took up the Zeebrugge service our deck officers were reduced from the usual complement of 15 to 10. The surplus 5 were distributed round the fleet. On 'HERALD'S' return to the Calais service, instead of our own Officers returning to the ship, we were and are being manned by officers from whichever ship is at refit. Due to this system, together with Trainee Master moves, 'HERALD' will have had a total of exactly 30 different deck officers on the books during the period 29th September to 5th January 1987....Many of the transient officers are only here for a few duties and in these circumstances their main concern is to get the ship loaded and safely between Dover and Calais. Although they are generally good officers it is unrealistic to expect them to become involved in the checking of installations and equipment or the detailed organisation of this particular vessel which they do not regard as their own...."

In a memorandum dated 28th January 1987 (Sheen, 1987g) the Captain said:

"I wish to stress again that HERALD badly needs a permanent complement of good deck officers. Our problem was outlined in my memo of 22nd November. Since then the throughput of officers has increased even further, partly because of sickness. During the period from 1st September 1986 to 28th January 1987 a total of 36 deck officers have been attached to the ship. We have also lost two masters (Hammond and Irving) and gained one (Robinson). To make matters worse the vessel has had an unprecedented seven changes in sailing schedule. The result has been a serious loss in continuity. Shipboard maintenance, safety gear checks, crew training and the overall smooth running of the vessel have all suffered....."
In reviewing the faults already described which led to this disaster there were the actions or lack of actions by the Master, the Chief Officer, the assistant bosun, and the failure of the Senior Master to issue and enforce clear operating procedures or orders. A wider view into the events that led up to the disaster identifies that the underlying faults lay higher up in the Company with the Board of Directors. It is ironic that they did not appreciate or understand their responsibilities for the safe management of their ships and therefore, did not apply their minds to the subject of what directions should have been given to all levels for the safety of their ships. Evidence showed that all concerned in management, from the members of the Board of Directors down to the junior superintendents, failed in their obligations and duties and must be regarded as being party to the failures of management. The report quotes:

'from the top to bottom the body corporate was infected with the disease of sloppiness.'

If the culture of a company is such that safety is outside the corporate framework, then it will be destined for failure. Information to provide guidance to such organisations is available, such as the Merchant Shipping Notice No. M. 1188 July 1986 entitled 'Good Ship Management'. The advice given in that Notice (Sheen, 1987h) included the following points:

"The efficient and safe operation of ships requires the exercise of good management both at sea and ashore....The overall responsibility of the shipping company requires the need for close involvement by management ashore. To this end it is recommended that every company operating ships should designate a person ashore with responsibility for monitoring the technical and safety aspects of the operation of its ships and for providing appropriate shore based back-up.....Stress is placed upon the importance of providing the Master with clear instructions to him and his officers. The instructions should include adequate Standing Orders. There should be close co-operation and regular and effective communication in both directions between ship and shore."

It could be argued that it is very sound advice but in a well-run ship-owning Company such advice should not have been necessary to have ensured that its operational
procedures complied with that advice. The report only identifies one example of how the standard of management fell short of the recommendations contained in that Notice. It reveals a culture of complacency and is quoted (Sheen, 1987i) as follows:

"On the 18th March 1986 there was a meeting of senior Masters with management, at which Mr Devlin was in the Chair. One of the topics raised for discussion concerned the recognition of the Chief Officer as Head of Department and the roles of the Maintenance Master and Chief Officer. Mr Devlin said, although he was still considering writing definitions of these different roles, he felt 'it was more preferable not to define the roles but to allow them to evolve.' That attitude was described by Mr Owen, with justification, as an abject abdication of responsibility. It demonstrates an inability or unwillingness to give clear orders. Clear instructions are the foundation of a safe system of operation. It was the failure to give clear orders about the duties of the Officers on the Zeebrugge run which contributed so greatly to the causes of the disaster. Mr Clarke, on behalf of the Company, said that it was not the responsibility of Mr Devlin to see that the Company orders were properly drafted. In answer to the question, 'Who was responsible?' Mr Clarke said 'Well in truth, nobody, though there ought to have been'. The Board of Directors must accept a heavy responsibility for their lamentable lack of directions. Individually and collectively they lacked a sense of responsibility. This left, what Mr Owen so aptly described as, 'a vacuum at the centre.'"

*Note: Mr Devlin was the Chief Marine Superintendent and in 1986 he became a Director of the company. Mr Ayes was a Director.*

The report determined that the investigation identified other failures on the part of the management, which emerged in the evidence and while they did not contribute to the disaster they are part of a poor culture that infected the Company, and they are matters of public concern. The culture was in part formed through the failures in the Standing Orders which to quote were (1) they made no reference to closing the bow and stern doors, and (2) they appear to have led the Captain to assume that his ship was ready for sea in all respects merely because he had no report to the contrary.
Another aspect was the failure to identify or accept responsibility at board level. For example the report states that Mr Devlin was prepared to accept that he was responsible for the safe operation of the Company's ships and added that he thought that before he joined the Board, the safety of the ships was a collective Board responsibility. Mr Ayers another director, told the Court that no director was solely responsible for safety.

The report continues (Sheen, 1987i) to define the culture:

"When Mr Devlin was asked who was responsible for considering matters relating to safety in the navigation of the Company's ships, his answer was 'shore, the system would be to take a consensus of the senior masters'. However, as the investigation developed, it became clear that the management onshore took virtually no notice of what they were told by their ships Masters. The evidence of that was highlighted when it was stated that there was one period of two and a half years during which there was no formal meeting Management and Senior Masters. The court heard that the 'Marine Department' did not listen to the complaints or suggestions or wishes of their Masters."

The report is quoted (Sheen, 1987j) on four specific areas in which the voice of the Masters fell on deaf ears ashore. Those areas were:

"(a) Complaints that ships proceeded to sea carrying passengers in excess of the permitted number.

(b) The wish to have lights fitted on the bridge to indicate whether the bow and stern doors were open or closed.

(c) Draught marks could not be read. Ships were not provided with instruments for reading draughts. At times ships were required to arrive and sail from Zeebrugge trimmed by the head, without any relevant stability information.

(d) The wish to have a high capacity ballast pump to deal with the Zeebrugge trimming ballast.\"
The Court reluctantly concluded that Mr Young made no proper or sincere effort to solve the problem. There was sufficient evidence to show a culture within the company where the shore staff of the Company were well aware of the possibility that one of their ships would sail with the stern or bow doors open, but took no action. Furthermore, they were aware of the existence of very sensible and basic device in the form of indicator lights that would indicate the status of the doors on the bridge, which had been suggested by responsible Masters but ignored by management. The report (Sheen, 1987k) makes it clear that those charged with the management of the Company's Ro-Ro fleet were not qualified to deal with many nautical matters and were unwilling to listen to their Masters, who were well qualified, and so did not provide to them the confidence and backing of the management.

The trial of P&O European Ferries (Dover) Ltd was terminated (Law Commission, 1996k) when the judge gave directions to the jury that, because of the law, there was no evidence available upon which they could convict six of the eight defendants, including the company, of manslaughter. The main reason for this direction in respect to the case against the company, was that, in order to convict it of manslaughter, they would have to identify one of the individual defendants with the company, and this individual would have to be guilty of manslaughter. Because there was insufficient evidence on which to convict any of the individual defendants, there was no prospect of a conviction against the company.

Turner (Law Commission, 1996l) ruled against the introduction of the 'principal of aggregation'. Had this principal been adopted it would have enabled the failings of a number of different individuals, none of whose failings would individually have amounted to the mental element of manslaughter, to be aggregated, so that in their totality they might have amounted to such a high degree of fault that the company could have been convicted of manslaughter. The report states that:

"because of the rejection of the 'aggregation' approach, the company could only be convicted if an individual who could properly be said to have been acting as the embodiment of the company was also guilty"
The basis on which the judge made his decision (Law Commission 1996m) is quoted as follows:

“In reaching his decision about the individual defendants, Turner J applied what was, in the period between Seymour and Prentice, thought to be the ruling law for manslaughter, the recklessness test of Caldwell and Seymour. He said: Before any of these defendants...could be convicted..., it was necessary for the prosecution to prove as against each such defendant not just one or more of the failures alleged against them in the indictment, but that - and this is the nub of the present situation - such failures were the result of recklessness in each defendant, in the now legally approved sense that they either gave no thought to an obvious and serious risk that the vessel would sail with her bow doors open, when trimmed by the head, and capsize, in circumstances unknown to shipboard management, or, alternatively, that if thought or consideration to that risk was given, each defendant, nevertheless, went on to run it.”

The case faltered on the basis that there was insufficient prosecution evidence to justify a finding that the risk of the vessel putting to sea with her bow doors open was ‘obvious’. The report (Law Commission, 1996n) identifies that appropriate test of ‘obviousness’ in this case was:

“what the hypothetically prudent master or mariner or whosoever would have perceived as obvious and serious.”

The report continues to state that:

“an ordinary person, with no experience of shipping, could not be expected to perceive this possibility as an obvious risk in an unfamiliar and complete system.”

In the terms of general safety and risk management the test balanced against the facts of the case are a cause for concern. It must be argued that even to the ordinary person, a ferry leaving port with its bow doors open, exposing a large open car deck is an obvious risk to the vessel. One would seriously doubt the competence of any mariner who did not perceive that risk whatever the system or pressure placed upon him.
In fact, the management engaged in the ferry business who evaluated the risks posed to their ships, needed only to look back into the history (Anon, 1988) of car ferry disasters to identify the incident of the Irish Sea car ferry, *Princess Victoria*, which sank on January 31 1953 with a loss of 128 lives. At the inquest a member of the crew stated that the ferry had sailed with the cargo doors open. A wave hit the ship and water swept onto the car deck moving the cargo to the starboard side of the vessel and causing it to list.

In the *Herald* case, the prosecution made the argument that the test should operate in a similar way to the test of 'foreseeability' employed in cases of civil negligence. This would have allowed the jury to infer that the risk of the ship sailing with her bow doors open was obvious, and that the safety system in place was defective and that the defect had allowed that disaster to happen. The report (Law Commission, 1996o) highlights the response of the judge who stated:

"recklessness in manslaughter was intended to be more culpable than ordinary civil negligence: the criterion of reasonable foreseeability of the risk was not appropriate. Instead, it was necessary to show that the risk was 'obvious' in the sense that it would actually have occurred to a reasonably prudent person in the position of the defendant. What was required was some evidence upon which the jury, being properly directed, can find that the particular defendant failed to observe that which was 'obvious and serious', which words themselves convey a meaning that the defendant's perception of the existence of risk was seriously deficient when compared to that of a reasonably prudent person engaged in the same kind of activity as that of the defendant whose conduct is being called into question."

The report (Law Commission, 1996p) continues to say that the prosecution evidence did not go far enough on this issue. It consisted of the testimony of a number of ships' master who were, or had been, in the employment of the defendant company, who all said that it had not occurred to them that any risk existed, let alone that it was an obvious one. This evidence must be considered to be of major concern, because as already stated, the obviousness of the risk could be accepted by an ordinary person. The one aspect of this evidence that supported the prosecution's case against the
company was the allegation that no-one in the company had given any thought to the risks. In addition the prosecution was not able to advance its case through the evidence of witnesses from other shipping companies that the risk was 'obvious'.

The successes and failings of these cases highlight the fact that there are key elements that form the basis of establishing a manslaughter at work prosecution. Under the current law it is doubtful if a successful case could be brought against a large Corporation. The evidence shows that the Directors of P&O European Ferries (Dover) Ltd had prior knowledge that the company fell short in its safety culture, and failed to do anything about this yet were not held liable under the present law. In the case of GWT, Judge Scott Baker could not identify the person responsible for health and safety in the company.
CHAPTER 4 - KEY ELEMENTS OF MANSLAUGHTER
AT WORK & PROTOCOL

This chapter will review the key elements involving a corporation in respect to manslaughter at work prosecution under the present law, and the implications under the proposed offence of Corporate Killing. As the law stands there must be an 'undertaking' which comprises, directors, managers and employees, including those who direct the activities of the company and can be identified as the 'controlling minds'. It is a statutory duty for all employers to take care of their employees and those not employed but who may be affected by the company's activities, and this is achieved through the identification of hazards, either created or encountered through work, and risks assessed. This means that care must be achieved through a safe system of work, which encompasses all aspects of the company's activities. In addition to the management ensuring a safe system of work and its duty of care, there is a need for competent staff to be employed. If there is a failure within the corporate entity then there may be negligence, and if the standard of negligence is serious, then it can be the basis of a case for corporate and/or individual manslaughter. The corporate manslaughter element in the proposed offence, titled Corporate Killing is quoted from the draft Bill (Law Commission, 1996q):

(1) A Corporation is guilty of Corporate Killing if -

(a) a management failure by the corporation is the cause or one of the causes of a person's death; and

(b) that failure constitutes conduct falling far below what can reasonably be expected of the corporation in the circumstances.

(2) For the purposes of subsection (1) above -

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(a) there is a management failure by a corporation if the way in which its activities are managed or organised fails to ensure the health and safety of persons employed or affected by those activities; and

(b) such a failure may be regarded as a cause of a person's death notwithstanding that the immediate cause is the act or omission of an individual.

(3) A corporation guilty of an offence under this section is liable on conviction on indictment to a fine.

4.1 MANAGEMENT IDENTIFICATION AND CONTROLLING MIND

The evidence clearly shows that while under the present manslaughter law an individual needs to be ‘identified’ as being negligent for there to be a manslaughter prosecution, the proposed Bill places the onus on management failure. That extends to the management failing to manage its activities, based upon what should be expected from the operations of a company in the circumstances of the incident. It further extends the liability to the management in the situation where an individual has caused the incident. This encompasses the boardroom level of management, who will be examined for their failure to ensure the safety of those employed and not employed but affected by their failings.

For there to be the basis of Corporate liability for manslaughter there must be a business or enterprise, and under present law, it would have to be incorporated as a Limited Liability Company (Ltd) or a Public Liability Company (Plc) where there is a Board of Directors. Businesses that are outside of these criteria, such as Partnerships, and the Self Employed; are classified as individual members of the organisation and would in the event of negligence face a charge of manslaughter as an individual.

The Law Commission's report No 237 (Law Commission, 1996r) focuses the proposed new offence on incorporated companies, which would exclude for example Hospital Trusts and Partnerships. It is recognised that the proposed offence of Corporate Killing is founded upon failures in the safety management system of an
organisation, or negligence on the part of an individual. However, the same failures
would apply whether the corporation is an incorporated or unincorporated
organisation.

At the consultation stage for preparation of the final Bill the Health and Safety
Executive and others interested parties, such as the Home Office, Police and Crown
Prosecution Service could be expected to propose to the Law Commission that all
corporations, both incorporated and unincorporated be eligible for the Corporate
killing offence. It therefore follows that the description of the enterprise could be an
'undertaking' to conform with the Health and Safety at Work Etc 1974 Act in which
Section 3(1) of the Act refers to the duty of every employer to 'conduct his
undertaking' in such a way as to avoid exposure to risk. (HMSO, 1974a) This would
then encompass businesses of all descriptions, types and size, bringing them clearly
into the sphere of corporate liability.

While there is no legal definition of 'undertaking', there are definitions that have been
adopted by the Health and Safety Executive. In a leading Health and Safety
handbook, (Redgraves, 1998a) the following definition is provided:

"An undertaking includes one for the provision of services, and is 'conducted' by the
employer even when shut down for maintenance purposes R v Mara [1987] 1 WLR
1987 SCCR 25, it was stated that the conduct of the undertaking was not limited to
the industrial process but would also cover trading and supplying or selling to
customers."

Further clarification was made when the phrase 'conduct his undertaking' was made
by the Court of Appeal in Associated Octel Co Ltd (1994) (Law Commission, 1996s).

"The court made it clear that the offence was concerned with a wider spectrum of
activities than those under the company's control. All that the prosecution had to
show, the court held, was that the activity in question was part of the conduct of the
employer's undertaking. It was then for the employer to show, if she could, that it was
not 'reasonably practicable' to prevent the accident."
In the legal context the clarification made by Stuart-Smith (Law Commission, 1996t) who when giving the judgement of the court provided more detail, when he said:

"The word 'undertaking' means 'enterprise' or 'business'. The cleaning, repair and maintenance of plant, machinery and buildings necessary for carrying on business is part of the conduct of the undertaking, whether it is done by the employer's own employees or by independent contractors. If there is a risk of injury..., and, a fortiori, if there is actual injury as a result of the conduct of that operation, there is prima facie liability, subject to the defence of reasonable practicability."

These statements provide a broad based understanding of the meaning ‘undertaking’ which if adopted in the proposed corporate offence would encompass all aspects of an ‘at work’ situation and place liabilities on those in ‘control’ or ‘directing’ an undertaking, whether they are a Director, Senior Manager, Partner or Trustee as they could be construed to be a ‘controlling mind’.

Under the present law there is a requirement to ‘identify’ a person for there to be either a corporate or individual manslaughter charge laid. In the corporate situation that person must be in a position of real authority and be culpable. While it may be possible to identify a person, such as the chairman, managing director or chief executive, the failing under present law is the culpability of the individual. This means that the ‘controlling mind’ has to have knowledge of, countenance or direct an act that he knows is unsafe and ignores the risk of harm to employees and/or non-employees. This identification process has been the cause of failure in Corporate Manslaughter cases.

The ‘identification’ principle laid down in the case Tesco Supermarkets v Nattrass, (1971) distinguishes between those agents of a company that qualify as its ‘controlling minds’ and those that do not. The main reason for this is that the principle requires the prosecution to ‘identify’ one or more ‘controlling minds’ who are themselves guilty of a manslaughter offence. (Law Commission, 1996u)
After conviction the company appealed (Law Commission, 1996v) to the House of Lords where Lord Reid said;

"that a company may be held criminally liable for the acts only of the board of directors, the managing director and perhaps other superior officers of a company (who) carry out the functions of management and speak and act as the company...."

Viscount Dilhorne, proffered another view (Law Commission, 1996w) and said;

"that a company should only be identified with a person who is the actual control of the operations of a company or of part of them and who is not responsible to another person in the company for the manner in which he discharges his duties in the sense of being under his orders."

Lord Diplock had a separate opinion (Law Commission, 1996x) and thought that the question was to be answered by;

"identifying those natural persons who by the memorandum and articles of association or as a result of action taken by the directors or by the company in general meeting pursuant to the articles are entrusted with the exercise of the powers of the company."

The Law Commission accepts that if the tests outlined above were applied strictly, they would produce rather different results. The test quoted by Viscount Dilhorne would appear to be stricter than the others, and there are very few people in a company who are not responsible to others for the manner in which they carry out their duties. However, the general principle is clear, and the courts must attempt to identify the 'directing mind and will' of the corporation, and the process of such 'identification' is a matter of law. Lord Diplock provided a logical opinion in that those who control a company are readily identified through formal registration and therefore the onus of liability is placed upon a small number of people.

It is important to note that under the principles clearly stated in the Tesco case Lord Pearson (Law Commission, 1996y) considered that a branch manager was not regarded as a controlling officer with the following explanation:

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"In the present case the company has some hundreds of retail shops, and it would be far from reasonable to say that every one of its shop managers is the same person as the company.....Supervision of the details of operations is not normally a function of higher management; it is normally carried out by employees at the level of foreman, charge hands, overlookers, floor managers and 'shop' managers (in the factory sense of 'shop')."

The Law Commission accepts in the report (Law Commission, 1996z) that there is little direct authority on the matter, but considers that it would seem right in principle that:

"the person who is identified with the corporation renders it liable only so long as she acts within the scope of her office."

In the Tesco case it was shown that there are things done in the management and organisation of the company, and there are things done at purely operational level. It is this factor the Law Commission focuses on, and rather than continue with the 'identification' principle, it would be more appropriate to look at the failure in the management system that can incur liability, rather than the status of the person or persons responsible for it.

The commentary (Anon, 1995) of the case R v British Steel Plc, (1995) provides a review of the 'controlling mind' issue with the following statement:

"The 'directing mind' argument. Where a statutory duty to do something is imposed on a particular person (here, an 'Employer') and he does not do it, he commits the actus reus of an offence. It may be that he has failed to fulfil his duty because his employee or agent has failed to carry out his duties properly but this is not the case of vicarious liability. If the employer is held liable, it is because he, personally, has failed to do what the law requires him to do and he is personally liable. There is no need to find someone - in the case of a company, the 'brains' and not merely the 'hands' - for whose acts the person with the duty can be held liable. The duty on the company in this case was 'to ensure' - ie make certain - that persons are not exposed
to risk. They did not make certain. It does not matter how; they were in breach of their statutory duty and, in the absence of any requirement of *mens rea*, that is the end of the matter."

There is therefore a logical acceptance that the ‘controlling minds’ have responsibility, regardless as to whether they do the work. This clearly places the duty of care on the management who direct the company’s activities.

### 4.2 Employers’ Legal Obligations - A Duty of Care

Employers have a prime duty under the Health and Safety at Work etc Act 1974 for the care of its employees and those not in its employment. Therefore, there is an obligation to provide a safe place and system of work.

Section 2 (1) of the Act (HMSO, 1974b) states;

“It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.”

Section 3 (1) of the Act (HMSO, 1974c) states;

“It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health and safety.”

This obligation is the responsibility of an employer and not connected to any liability that may arise in respect of injury caused to an employee by a fellow employee in the course of their employment. A breach of the employees obligation is not just negligence but is the employer’s own negligence.

In the civil law case *Wilsons and Clyde Coal Co Ltd v English* [1938]. Lord Wright (1938) explained the general nature of the employer’s obligation as;
"...........a duty rests on the employer and which is personal to the employer, to take reasonable care for the safety of his workmen, whether the employer be an individual, a firm, or a company, and whether or not the employer takes any share in the conduct of the operations."

When courts seek guidance on the question of duty and liability they can refer to the case of *Donoghue v Stevenson* where Lord Atkin (1932) said;

"The duty which is common to all cases where liability is established must be logically be based upon some element common to the cases where it is found to exist. There must be, and is, some general conception of relations giving rise to a duty of care, of which the particular cases found in the books are but instances. You must take reasonable care to avoid acts or omissions which you reasonably foresee would be likely to injure your neighbour. Who then, in law is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

Munkman (1990) explains that this passage does not determine a finite or general rule of law, but provides a guide, which is followed in deciding whether a duty of care exists, unless there is good reason to the contrary.

It can be considered that there are three main areas encompassing a duty of care which were the summarised dictum of Scott (1947) in the case of *Vaughan v Ropner & Co Ltd* when he said;

"The three main duties [of the employer] are (1) to provide proper premises in which, and proper plant and appliances by means of which, the workman's duty is to be performed; (2) to maintain premises, plant and apparatus in a proper condition; (3) to establish and enforce a proper system of working."

It follows that in order that a corporation can undertake its obligations of a 'duty of care' there needs to be a Safety Management System (SMS) that encompasses all aspects of the undertaking and provides for safe systems of working.
The term 'safe system of work' is broadly based and includes the planning of the work, and the way in which it is required to be carried out, as well as the provision of adequate instructions. Precautions have to be made to account for the safety of the workers at all times. This includes having sufficient persons to do the job, and that those persons are competent to undertake the work tasks. This is highlighted by Lord Oaksey (1953) in the case General Cleaning Contractors Ltd v Christmas, (1953), who said:

“It is the duty of an employer to give such general safety instructions as a reasonably careful employer who has considered the problem presented by the work would give his workmen.”

Lord Oaksey (1953) continued to state:

“It is....well known to employers....that their workpeople are very frequently, if not habitually, careless about risks which their work may involve. It is....for that very reason that the common law demands that employers should take reasonable care to lay down a reasonably safe system of work. Employers are not exempted from this duty by the fact that their men are experienced and might, if they were in the position of an employer, be able to lay down a reasonably safe system of work themselves. Workmen are not in a position of employers. Their duties are not performed in the calm atmosphere of a board room with the advice of experts. They have to make their decisions on narrow sills and other places of danger and in circumstances where dangers are obscured by repetition.”

Lord Reid (1953) said in the same case:

“Where the practice of ignoring an obvious danger has grown up I do not think that it is reasonable to expect an individual workman to take the initiative in devising and using precautions. It is the duty of the employer to consider the situation, to devise a suitable system, to instruct his men what they must do and to supply any implements that may be required.”
The general consensus of the legal ruling and commentators regards the definition of what is a safe system of work as being broad and open to interpretation. It is therefore a matter of fact and will be a matter for a Judge and Jury to determine.

This objective is supported by Clarkson (1996) who states:

"In implementing or failing to implement a policy or system, it is the decision-making of the company that is open to judgement, whether praise or blame. As in the P&O case, it might be impossible to assess why no safety system had been introduced or to pinpoint any individual who could be held responsible for the failure. The company, as a company, had failed in its duties; it was a company that was responsible and blameworthy. It failed to take advantage of a fair opportunity to avoid wrongdoing and can be held culpable......the absence of proper safety systems in an organisation demonstrates an undesirable character trait of practical indifference. The board of P&O had been warned of the dangers of previous open-door sailing and allegedly responded with facetious comments. The 'sloppiness' that 'infected' the company 'from top to bottom,' and the resultant harm, can be regarded as the product of the bad character of the company itself and not just of senior personnel."

In the present context the duty to provide a safe system of work is very important as it requires a company to plan all of its working operations in advance with particular consideration to ensuring safety. This is well defined by Munkman (1990) in Employer’s Liability at Common Law:

"The state of the premises and plant, and the choice and supervision of personnel, fall especially within the employer’s province. In adding as a further component the system of work, the law does no more than adopt and clarify a distinction accepted in everyday life. The employer is responsible for the general organisation of the factory, mine or other undertaking; in short, he decides the broad scheme under which the premises, plant and men are put to work. This organisation or 'system' includes such matters as co-ordination of different department and activities; the lay-out of plant and appliances for different tasks; the method of using particular machines or carrying out particular processes; the instruction of apprentices and inexperienced workers; and a residual heading, the general conditions of work, covering such things as fire
precautions. An organisation of this kind is required - independently of safety - for the purpose of ensuring that the work is carried on smoothly and competently; and the principle of law is that in setting up and enforcing the system, due care and skill must be exercised for the safety of the workmen. Accordingly, the employer's personal liability for an unsafe system - independently of the negligence of fellow-servants - is not founded on an artificial concept, but is directly related to the facts of industrial organisation."

It is clear that the onus is on the employer to ensure that there is a safety management system in operation, that it works and is adopted by all of the employees and that the management cannot disassociate itself from these requirements. The problem occurs when the failure to provide a safe system and or place of work is so serious that it is considered to be Corporate Manslaughter. In this situation an individual has to be 'identified' as being negligent rather than the corporate body having failed in its obligations. Placing the liability onto the corporation is one of the objectives of the proposed corporate offence.

As a conclusion to the provision of a safe system of work question Holgate (1995) suggests that:

"Associated Octel is a most important decision which can only enhance workplace health and safety....In order to avoid liability, the prudent employer/principal will henceforth be well advised to adopt a 'hands on' approach to the activities of contractors engaged by them, stipulating the necessary safety precautions and procedures and ensuring that they are complied with."

The two key words are hazard and risk. In the most basic explanation (Croner, 1998) a hazard can be defined as something with the potential to cause harm or injury, while a risk can be defined as the likelihood of harm or injury arising from a hazard. Therefore, the management needs to identify any hazards that are created or encountered by their employees while at work and evaluate the risks that may be faced. They can then remove or reduce the risks to as low as reasonably practicable. The senior management may not be aware of the potential harm that could be created within their company, and they may need to employ competent persons to assist them,
but ultimately, they as the directing management of the company, still have the responsibility for health and safety within their organisation.

Assessing risks to employees is not new, as identified by Lord Morton (1951) who in *Paris v Stepney Borough Council* states:

"There are occupations in which the possibility of an accident occurring to a workman is extremely remote, while there are other occupations in which there is a constant risk of accident. Similarly, there are occupations in which if an accident occurs, it is likely to be of trivial nature, whilst there are other occupations in which...the result...may well be fatal...there has to be in each case a gradually ascending scale between the two extremes...the more serious the damage which will happen if an accident occurs, the more thorough are the precautions which an employer must take."

This is further clarified by Lord Reid (1956) who in the case *Morris v West Hartlepool Steam Navigation Co Ltd* said:

"It is the duty of an employer in considering whether some precautions should be taken against foreseeable risk, to weigh, on the one hand, the magnitude of the risk, the likelihood of an accident occurring and the possible seriousness of the consequences if an accident does happen, and, on the other hand, the difficulty and expense and any other disadvantage of taking precaution."

A high standard of care must be taken when the defendant knows that there are particular risks, and where the defendant knows of risks of which others are ignorant. His conduct should be judged upon the defendant’s knowledge of the risks. In the case *Stokes v Guest, Keen and Nettlefold (Bolts and Nuts) Ltd* 1968, Swanwick (1968) said:

"...the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of common sense or newer knowledge it is clearly bad; but, where
there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it; and where he has in fact greater than average knowledge of the risks, he may be thereby obliged to take more than average or standard precautions. He must weigh up the risks in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probable effectiveness of the precautions that can be taken to meet it and the expense and inconvenience they involve. If he is found to have fallen below the standard to be properly expected of a reasonable and prudent employer in these respects, he is negligent.”

4.4 RISK ASSESSMENT

Because of the importance of risk assessment the Health and Safety Executive produced a guidance, 5 Steps to Risk Assessment (HSE, 1995) which contains information on good practices, which while not compulsory, are of help to management in understanding what is required and how to set about undertaking risk assessments. The leaflet contains a blank risk assessment form that can be adopted by most businesses and industries, focusing on topics of identifying the hazards and identifying who might be harmed by those hazards. It requires the risk to be adequately controlled, and identify what further action is necessary to control the risks. The success of the guidance gave rise to an updated version needing to be produced. This document, Five Steps to Risk Assessment (HSE, 1998), retains the same message, setting the basis for employers and self employed to assess the risks in the workplace with the aim of ensuring that there are sufficient precautions taken to make sure that no gets hurt. It explains that accidents and ill health can affect a business, through lost output, machinery damage, increased insurance costs or court action. The Management of Health and Safety at Work Regulations (HSE 1992) state that there is a legal requirement to assess risks in the workplace. Based upon the fact that it is enshrined in law that risks have to be assessed and controlled, failures that cause deaths at work could show a management failure to heed advice and adopt safe practices. This in turn would an evidential factor in potential Corporate Killing prosecutions.
4.5 MANAGEMENT NEGLIGENCE

Management failure and negligence, while separate issues, are in the corporate sense closely linked because if the management has omitted to take suitable precautions, either when they knew or should have known, that failure could result in an accident, then there is negligence. The degree of negligence is a matter for the legal process to review and decide.

The accepted definition of negligence is determined in the judgement by Alderson (1856) in the case Blyth v Birmingham Waterworks Co who said:

“Negligence is the omission of something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or something which a prudent and reasonable man would do.”

There is the question of what is a reasonable man in this context and to that end an explanation is offered by Lord Macmillan (1943) in Glasgow Corpn v Muir [1943] who said:

“The standard of foresight of the reasonable man is in one sense an impersonal test. It eliminates the personal equation and is independent of the idiosyncrasies of the particular person whose conduct is in question. Some persons are unduly timorous and imagine every path beset with lions; others, of more robust temperament, fail to foresee or nonchalantly disregard even the most obvious dangers. The reasonable man is presumed to be free both from over-apprehension and from over-confidence.”

The management or persons who require special knowledge or skills in order to undertake or control their work are expected to have suitable knowledge of the risks and safety procedures that employees encounter in carrying out the work. This has been defined in part as (Munkman, 1990):

“In general, an employer is expected to keep reasonably abreast of current knowledge concerning dangers arising in trade processes, and should be acquainted with pamphlets
issued by the Health and Safety Executive and other safety organisations drawing
attention to risks which have come to light and means of avoiding them.”

The extent of knowledge balanced against liability to determine negligence is
discussed in Smith and Hogan (1988):

“Should Negligence be a Ground for Liability? Since the advent of Caldwell
recklessness much inadvertent risk-taking has been brought within criminal law.
Turner acknowledges that negligence connotes that D was; in some measure
blameworthy, and that we should expect an ordinary reasonable man to foresee the
possibility of the consequences and to regulate his conduct so as to avoid them.”

The question that follows is what constitutes negligence, and that is a matter of
establishing the facts that identify that the employer has failed to provide a safe place
and system of work. Munkman draws attention to the situation that there may be
three main elements to an employers personal duty, those being plant, place of work
and method of work. In addition the selection of supervisors and employees may be
included.

These elements are borne out in the case of Wilson v Tyneside Window Cleaning Co
[1958] where Parker (1958) said:

“The master’s duty is general, to take all reasonable steps to avoid risk to his servants.
For convenience it is often split up into different categories, such as tools, or safe
system of work, but it always remains one general duty.”

This is further clarified in the case Wilsons and Clyde Coal v English [1938] where
Lord Wright (1939) said:

“The obligation is threefold, the provision of a competent staff of men, adequate
material, and a proper system and effective supervision.”

There has been consideration by the House of Lords in respect to negligence where
Mackay (1994) said:
“In my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such a breach of duty is established the next question is whether that breach caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death......was such that it should be judged criminal.”

4.6 MANAGEMENT FAILURE

It can be seen that negligence by an employer can be identified as a failure by the management in identifying risks and making provision for them. It is the failure by management that is the focus of the Law Commission (1996aa) in its review of corporate liability and that discussion is quoted:

“The concept of 'management failure' is an attempt to define what, for the purpose of a corporate counterpart to the individual offence of killing by gross carelessness, can fairly be regarded as unacceptably dangerous conduct by a corporation. But it must of course be proved, as in the individual offence, that the defendant's conduct (which, in the present context, means the management failure) caused the death. To a large extent this will involve the application of the ordinary principles of causation, as in any other homicide offence. If, for example, the jury are not satisfied beyond reasonable doubt that the death would not have occurred had it not been for the management failure, the offence will not be proved. Even if the death would not otherwise have occurred, it will be open to the jury to conclude that the 'chain of causation' was broken by some enforceable act or event, and that the management failure was not itself a cause of the death but merely part of the events leading up to it. If, for example, the management failure consisted of a failure to ensure that some potentially dangerous operation was properly supervised, a jury would be unlikely to conclude that this failure caused the death if the immediate cause was a deliberate act by an employee rather than a merely careless one - even if that act would probably not have occurred had a supervisor been present. “
The Law Commission (1996 bb) concludes that under their recommendations:

"the crucial question would be whether the conduct in question amounted to a failure to ensure safety in the management or organisation of the corporation's activities (referred to as a 'management failure' for short). This would be a question of fact for the jury to determine."

The Law Commission's proposal would be to determine whether there had been a management failure, rather than, as the law requires at present, the apportion of blame on an individual or group of individuals which should in the circumstances be attributed to the company. It is recognised that there will be some cases in which the jury will have to determine the distinction between an employee's negligence and a management failure. The main emphasis will be where the employer leaves the identifying and taking of health and safety precautions to their workers, which may be a failure to discharge their duty to ensure a safe system of work.

An important issue is raised by Clarkson who argues that the offence of Corporate Killing is manslaughter and that by omitting the words 'manslaughter' the seriousness of the offence must be downgraded and states:

'The new crime of corporate killing..............would be committed when there was a 'management failure' (as opposed to 'operational negligence' by an employee that 'fell far below what could reasonably be expected of [the company] in the circumstances. This proposed offence would be additional to the Law Commission's new offence of reckless killing and killing by gross carelessness (which together could replace the existing crime of involuntary manslaughter), and companies could still be convicted of these other offences if the identification doctrine could be satisfied. This proposal has the advantage that it would facilitate convictions in such cases as P&O where there was clearly a 'management failure' that caused the deaths........the creation of a separate offence could mean that corporate killings would be perceived as different from 'manslaughter' or the new substitute offences. This could lead to a downgrading of the stigma and seriousness of the new offence, and could contribute to its marginalisation in terms of enforcement. If a company has killed recklessly or by gross carelessness, there are strong fair-labelling reasons that only a conviction for
the full offence will convey adequately the seriousness of the crime and communicate the appropriate of rejection of the wrongdoing.'

With the key elements of corporate manslaughter identified, there is a requirement for a safety management system that encompasses the entire company from boardroom through to the most junior employees. Such a system needs to an integral part of the corporate culture and not an 'add on'. Safety management systems are founded upon basic principles and evolved to be unique to an individual corporation.

4.7 A PROTOCOL FOR LIAISON

As part of the developing process to ensure effective investigation and legal process of accidents involving a death at work, a joint protocol (Appendix 1) has been drawn up by the Health and Safety Executive (HSE), the Association of Chief Police Officers (APCO) and the Crown Prosecution Service (CPS). (HSE 1998) The protocol is effective in England and Wales and where the HSE is the enforcing authority for health and safety legislation. The objective of the protocol is to draw the three organisations together where there has been a death at work to determine if there is evidence that there may be a case of individual or corporate manslaughter.

The three signatories to the protocol have different roles and responsibilities where there has been a work related death. The HSE has the function of enforcement of health and safety legislation within the scope of the Health and Safety at Work etc Act 1974. (HMSO 1974d) While the HSE can prosecute breaches of health and safety legislation, it cannot investigate or prosecute for general criminal offences, including manslaughter.

The police investigate criminal offences and that includes deaths at work. In this situation they are gathering evidence to identify if there has been a criminal act such as murder, manslaughter or unlawful act against a person by another person. The police do not have the expertise to investigate in detail, work related deaths, as their function is to gather evidence for the Coroner's Inquest. If it is considered that there
may have been a criminal offence committed, they can send the file to the CPS for consideration for prosecution.

The CPS will review the evidence which can be provided by the Police alone or a combined Police and HSE report. They will then decide if there is sufficient evidence for a realistic prospect of a prosecution and if it is the public interest to proceed.

Because neither the Police nor the CPS have expertise in or knowledge of, investigating work related deaths the adoption of the protocol will ensure effective co-operation throughout England and Wales. However, prior to the introduction of the protocol there were joint Police and HSE investigations, but it was very much a matter for individual Police forces and Police officers as to whether HSE Inspectors were involved. One example of HSE, Police and CPS co-operation was recorded by Smith (1998) who stated:

"The possibility of bringing charges of manslaughter against diving company personnel is likely to be considered for the first time next month as investigations into the death of a North Sea diver continue........The Heath and Safety Executive are working on parallel investigations. An inquest is expected to be held in the second week of October and any decision about criminal charges will be made by the Crown Prosecution Service."

In reality HSE Inspectors and Police officers worked together in the investigation of the case, the preparation for court and the trial itself. That evidence allowed the CPS to lay charges of individual manslaughter, perverting the course of justice, and health and safety offences, as was described by Welham (1998) in a paper given at Oriel College, Oxford University who stated:

"The three groups, HSE, Polices and CPS followed the spirit of the new Work Related Deaths - A Protocol for Liaison, even though at the time it had not been written. What is clear is that if adopted by all involved, it will work and work effectively."
There are other instances of HSE and Police co-operation in investigating and laying of charges prior to the introduction of the Protocol and these are identified through the following examples:

“Criminal charges brought after investigations by the Health and Safety Executive and the Police.” (Starrs, 1996)

“Custodial Sentences for Manslaughter in Gas Poisoning Case......The charges were brought following investigations by Ipswich Police and Inspectors from the HSE.” (HSE, 1998)

“Jackson Transport (Ossett) Ltd and its former Managing Director have both been convicted of manslaughter. The trial arose from a joint HSE/Police investigation....” (Anon, 1996)

“ A gas fitter and landlord were charged with manslaughter following an investigation by the HSE and Police.” (Anon, 1997)

The key points of the Protocol are:

• The HSE, Police and CPS will establish effective mechanisms for liaison.
• The HSE will investigate under the HSWA 1974 and pass information suggesting manslaughter to the Police or CPS.
• The Police will conduct an investigation where there is an indication of manslaughter.
• The decision concerning prosecution will be made based on a sound investigation of the circumstances surrounding work related deaths. It will be made by the CPS, HSE and Police without undue delay.
• The protocol has been signed up to and is public information.

In the event of a death at work the Police are notified as are the HSE. A police detective of supervisory rank should attend the scene. At this point the liaison between the Police and HSE will commence with a joint investigation. That initial investigation will identify whether there is a need for a Police involvement or whether
it is HSE investigation. If the Police decide that a charge of manslaughter or other serious offences cannot be justified, the investigation and forthcoming prosecution will undertaken by the HSE. Should the Police in liaison with the HSE decide that there may be a case to answer, then they will investigate for gross negligence or recklessness by either a company or an individual. In this situation the HSE will provide technical support to the Police and continue to investigate for offences under HSWA 1974.

When the investigations are completed a report is produced and provided to the CPS with recommendations for prosecution for manslaughter or other serious offences. The final decision of whether to prosecute and with what charges will be made by the HSE, Police and CPS in consultation. Where there are additional offences under the HSWA 1974 the HSE and CPS will consider the initiation of joint proceedings.

To ensure that the protocol is working and effective a two tier management system has been established. The first is where the HSE, Police and CPS have formed a national liaison committee, which meets at least once a year and will deal with high level issues. The second tier involves local liaison offices from each of the three groups, and they meet on a regular basis to discuss the day to day working of the protocol.

The protocol can be seen to be the first auditable step in the process of ensuring a level playing field for effective investigations into deaths at work, and a joint decision making process for charges of manslaughter or other serious offences. The second auditable step will be the implementation of new manslaughter legislation which will allow offences of Corporate Killing. This means that there will be more focus on deaths at work in respect to potential individual and corporate manslaughter. However, the problems encountered with the current status of manslaughter still remain. How many cases of potential corporate manslaughter prosecutions, under the existing law and proposed new offence, are the focus of the review of deaths at work data in Chapters 5 and 6.
CHAPTER 5 - RESEARCH METHODOLOGY

As part of the evaluation of potential Corporate Killing offences there was a need to review the wider aspect of accidents, both major and fatal, and the outcome of cases that have been referred to the Crown Prosecution Service (CPS) for consideration for Corporate Manslaughter. Major non-fatal accidents are included because they play a part in the overall serious incident statistics. In general the number of incidents decrease with increasing severity of injury. The assumption is based upon the work of Tye, (1975) Greater London Council, and Bird and Germain (1969). Although major non-fatal injury figures are included there is no correlation with the number of fatal injuries.

To achieve this review, a database has been established and the outcomes evaluated. To further extend the knowledge of the evaluation, a second data base identifies fatal accidents, the legal process outcomes, level of fines imposed and whether the case would be considered appropriate for a Corporate Killing prosecution under the proposed terms of the offence.

5.1 FINES

Although the level of fines is not directly related to the serious offence of manslaughter as they involve both fatal and non fatal accidents, fines for breaches of health and safety offences are an important indicator as to the level of seriousness with which the Judicial system views such offences. Fines can be determined to be a punishment, but there are other considerations as described by Clarkson (1996);

"a fine amounts to punishment of innocent shareholders, creditors, employees who might be made redundant, or the public who will ultimately have to bear the burden
of the fine. In short, the ones who will really suffer will be those whom the law is aiming to protect.”

The level of fines imposed for health and safety offences is recognised to be low and is an area of concern for both the Health and Safety Commission and exponents who claim that there is a failing in the level of penalties for all health and safety prosecutions. One reason for this is highlighted by Wells (1993a) who states:

“the word 'punishment' is dropped when corporations are the object of criminal enforcement and is replaced by the altogether less emotive 'sanction'.”

This downgrades the whole status of a corporation being in court, which will be of concern in the event of an injury, but if there is a fatality then the status of that death is in effect downgraded further, albeit in a criminal court. The discussion by Wells (1993b) is extended to the courts, both Magistrates’ and Crown who frequently require social reports to be prepared for individuals, prior to sentencing. However, with corporate defendants, there is generally no attempt made to investigate the financial background or assets, before imposing fines.

Fines are imposed either as a punishment or sanction depending upon the views that prevail with corporate crime. Smith and Hogan (1996) highlight the corporate implications in that:

“The fine imposed is ultimately borne by the shareholders who, in most cases, are not responsible, in sense for the offence. If they really had control over directors and so over the management of the company, this might afford some justification; but it is generally recognised that they have no such control over large, public companies. Since the persons actually responsible for the offence may, in the great majority of cases, be convicted, is there any need to impose this additional penalty? Arguments in favour of corporate liability are that there may be difficulty in fixing individuals with liability where someone among the 'brains' of the corporation has undoubtedly authorised the offence. Corporate liability ensures that the offence will not go unpunished and that a fine proportionate to the gravity of the offence may be imposed, when it might be out of proportion to the means of
the individuals concerned. The imposition of liability on the organisation gives all those directing it an interest in the prevention of illegalities, and they are in a position to prevent them, though the shareholders are not."

5.2 CASE EXAMPLES

With regard to fines and the implications for companies, the following is an example where a main contractor was instrumental in an accident, which was so serious that a fatality nearly occurred (Personal Communication, 1998). The company had documented health and safety procedures in place, which named one of the directors as being responsible for health and safety. That director was not only on site at the time of the accident, but was in charge of the site, and had full knowledge of the operations being undertaken. At the Magistrates’ court the prosecution case was presented with full emphasis on the implications, seriousness of the incident and corporate disregard for safety. The strength of the case presentation made mitigation virtually impossible, and so the defence focused on the effect high fines would have on the company and its employees, since it was in a high unemployment area where contracts were scarce and profits low. Heavy fines would mean some staff having to be made unemployed. The Magistrates commended the case presentation, understood and accepted the seriousness of the case, but were not prepared to impose a fine that would mean employees, who were not involved with the incident, losing their jobs. A financial penalty was therefore imposed that did not reflect the seriousness of the case. This method of determining the level of fine is based upon a solicitor making a statement to the court, having been provided with the information by the defendant. This poses the question whether if a corporate defendant is found guilty of an offence or pleads guilty, should a verbal statement of the corporate background and financial status be available. When submitting bids for contracts the company will have to provide substantial evidence of its financial status to ensure that it could undertake the work. Courts should require the same level of evidence.

The question of fines raises a number of issues and one highlighted by Wells (1993c) is provided in the example:
"British Rail was fined £250,000 and ordered to pay £55,000 prosecution costs for an admitted failure to ensure the safety of its employees and passengers following the Clapham rail collision in 1987. The judge was faced with an 'acute problem'......the fine could only be met either by increasing the burden on fare paying passengers or by reducing the finance available for improvement to the railway system."

Another example of the implications of heavy fines is that of a Health Care Trust which was fined £38,000 plus £17,000 costs. The Trust admitted that it failed to take the necessary steps to ensure the safe control of all stages of cardiac angiography procedures. As a consequence, a patient died after being injected with air instead of radio-opaque fluid during a routine cardiac angiography. The Health and Safety Executive news release (HSE, 1998) stated:

"The case highlights the need for the health care sector to manage health and safety at work properly, just like any other employer.....The investigation showed that it was not a failure of the equipment of itself, but a failure of the management to implement a safe system of work to deliver clinical judgement, which caused this tragic and avoidable death........In passing sentence [the Judge] said, This is an important case, raising issues not present in other cases concerning prosecutions of NHS trusts by the HSE......The failure in this case was the absence of a safe system of work to protect patients and employees, which arose from the use of this equipment."

The case was heard in the Magistrates' Court (George, 1998) but sent to the Crown Court for sentence where the level of fine is unlimited. The lawyer representing the NHS Trust told the court that every pound that the hospital is fined is a pound less spent on the care of our community.

The question of fines as opposed to other punishments for corporate health and safety offences will discussed later, but the NHS and British Rail cases are examples of the possible need to remove the burden of fines from the business output, in this case patient care and passenger fines or future safety, and provide the courts with alternative options.

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In a review of Corporate Manslaughter, Bergman (1999) identifies that only one study has been undertaken in reviewing the level of fines when balanced against the wealth of the company and states:

"The West Midlands Health and Safety Advice Centre obtained information on the annual profits of 65 of the 260 companies sentenced in the region between 1987 and 1993. The five companies with average profits of between £1-10,000 received an average fine of £750 per offence - 16 per cent of their profits. Companies with profits of between £100-150,000 received fines of between £1290 per offence - 0.5 per cent of their profits. The five companies with profits of over £10 million received average fines of £1185, equivalent to 0.002 per cent of their profits."

The same concerns about the level of fines were discussed by Davies (1996), Chairman of the Health and Safety Commission, who reviewed how Magistrates' Courts reacted to health and safety cases. The key issue was addressed in the opening paragraph where he stated:

"Fines for health and safety offences are too low. Employers who cause injury, or even death, get off lightly. These are views which we hear from members of the public as well as the media.............. When prosecution and conviction follow, only the courts can decide penalties which send the right message: that risks to health and safety must be controlled........ Experience shows that the size of the fine has an important impact on preventative work with firms. If a court rewards with low fine the good fortune of an employer whose crime did not result in injury or death, other employers may believe they can neglect health and safety with impunity."

The status of fines for health and safety cases is set to change following the judgment of an appeal by F. Howe & Sons (Engineering) Ltd (Anon, 1999) against a fine imposed by a court after a fatal accident.

"Repeated calls from the Health and Safety Commission and Government Ministers for higher fines to be imposed for health and safety offences appear to have been answered by a recent Court of Appeal ruling. The ruling concluded that fines for health and safety offences are too low is expected to lead to more
health and safety offences being heard before the Crown Court, where judges can impose unlimited fines. Currently, the majority of health and safety cases are heard in the Magistrates' Courts, where the maximum fine that can be imposed for breaches of the Health and Safety at Work Act 1974 is £20,000. The Court of Appeal concluded that fines for health and safety offences must be large enough to bring home to those who manage a company, and their shareholders, the need for a safe environment for workers and the public. However, although it stated that fines should not be so large that they put the company at risk of bankruptcy or place the earnings of employees at risk, it said that there may be cases where the offences are so serious that the defendant ought not to be in business. Magistrates and judges should take into account any aggravating features when passing sentence in health and safety cases. These included whether there was a deliberate breach of health and safety legislation with a view to profit and if there was a failing to heed warnings. Where death is the consequence of a criminal act, it should be regarded as an aggravating feature of the offence, and the penalty should reflect public disquiet at the unnecessary loss of life. The Court of Appeal has said that health and safety fines are too low. The judgement will help to ensure that the courts recognise the seriousness of health and safety crimes and punish the perpetrators appropriately.”

The courts have a role to play in the legal process, both in the level of fines and whether a case should be transferred from the Magistrates' Court to the Crown Court. The former has limits on the level of fines that can be imposed, while the latter does not.

5.3 DEATHS AT WORK DATA

Fatal injuries are categorised by the Health and Safety Commission for the period 1992/93 to 1997/98 into fatal injuries to employees, fatal injuries to the self employed and fatal injuries to members of the public. The Health and Safety Executive gathers its data for deaths at work through Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985 and 1995 (RIDDOR 85 and 95) returns. It is considered that the data on employers, employees and self employed are accurate but
acknowledges that the death of some members of the public may not be captured by the system.

Injury statistics for 1996 - 1997 and 1997 - 1998 are compiled from reports to the Health and Safety Executive and Local Authorities under RIDDOR 1995, which came into force on 1 April 1996. There are a number of differences between RIDDOR 95 and the previous reporting Regulation RIDDOR 85. Under RIDDOR 95 the definition of a major injury to a worker is wider, and injuries caused by acts of physical violence are reportable (Health and Safety Commission, 1998a).

Table 5.1 shows fatal injuries to employees, self employed and members of the public for 1992/93 to 1997/98. The period of the review presented here commences in 1992 to coincide with the introduction of the Management of Health and Safety at Work Regulations 1992 (HSE, 1992).

Table 5.1 FATAL INJURIES (HSC, 1998)

<table>
<thead>
<tr>
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<tr>
<td>A</td>
<td>339</td>
<td>296</td>
<td>272</td>
<td>258</td>
<td>287</td>
<td>268</td>
<td>1,720</td>
</tr>
<tr>
<td>B</td>
<td>276</td>
<td>245</td>
<td>191</td>
<td>209</td>
<td>207</td>
<td>210</td>
<td>1,338</td>
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<td>C</td>
<td>63</td>
<td>51</td>
<td>81</td>
<td>49</td>
<td>80</td>
<td>58</td>
<td>382</td>
</tr>
<tr>
<td>D</td>
<td>113</td>
<td>107</td>
<td>104</td>
<td>86</td>
<td>367</td>
<td>397</td>
<td>1,174</td>
</tr>
</tbody>
</table>

A Fatal injuries to employees and self employed as reported to all enforcing authorities by industry 1992/93 to 1997/98.
B Fatal injuries to employees as reported to all enforcing authorities by industry 1992/93 to 1997/98
C Fatal injuries to the self-employed as reported to all enforcing authorities by industry 1992/93 to 1997/98
D Fatal injuries to members of the public as reported to all enforcing authorities by industry 1992/93 to 1997/98
From these figures, which cover a five year period, 1720 persons died while employed in some capacity. In addition there were 1174 deaths for the same period involving members of the public. They were killed through the acts or omissions of others who were at work, either as an employer, employees or self employed.

A summary of fatal and non-fatal injuries for 1997/98 (HSC, 1998b) is:

Fatal injuries for 1997/98 for all employees are expected to be 210 which will be 0.9 per 100,000 employees. This is the lowest level since 1981

Non-fatal major injuries for 1997/98 for all employees are expected to be 28,880, an increase of 3% compared with the previous year

Fatal injuries to the self employed in 1997/98 are expected to be 58 compared with 80 fatalities in 1996/97. This will be 1.7 per 100,000 self employed workers.

Non-fatal major injuries for 1997/98 for the self employed are expected to be 814, a decrease of 40% compared with the previous year.

Fatal injuries to members of the public in 1997/98 are expected to be 397 compared to 367 fatalities in 1996/97. This will be an 8% increase.

The number of non-fatal injuries to members of the public is expected to decrease substantially from 35,694 in 1996/97 to 28,309 in 1997/98.

While this data is extremely valuable it does not meet the requirements of the study which seeks more case detail for case of deaths at work and those which are potential manslaughter cases.

5.4 METHODOLOGY

A literature review was undertaken to obtain the information, but as identified above there are no official data available that meet the criteria of the research objectives. Statistical data for fatal and major non-fatal accidents and information's laid is readily available from the Health and Safety Commission statistical publication *Health and*
Safety Statistics 1997/98 (Health and Safety Commission, 1996c): A review of that data identified that the statistics available only provide base line figures for accidents and deaths at work covering employees and those not employed. There was no established formal data available that identified 'at work' fatalities providing case details of the number of deaths, cause of death and action by any authority in respect to manslaughter prosecution. Therefore, the study required evidence to be gathered to create a database of fatal accident cases, and evaluate the outcome in respect of whether a manslaughter case was pursued.

With no official or unofficial source of data identified the information had to be obtained, and therefore databases had to be developed that would encompass the base line information required. There are two separate objectives with equally separate outcomes. It was evident that there was a need to develop two databases. One database would identify cases considered for manslaughter prosecutions, while the second database would identify HSE prosecution cases and identify outcomes in terms of fines.

To establish parameters, the Manslaughter database commences in 1992 to conform with the introduction of the Management of Health and Safety at Work Regulations 1992, to include cases of both Corporate Manslaughter and Individual Manslaughter. The Deaths at Work database encompasses the years 1996 - 1999. A three year data coverage was selected which is a shorter period than those cases considered for the manslaughter prosecution, as the principal focus was on the serious offence, combined with the limited sources of suitable data. All options of data availability were explored with a negative result and so research was focused on potential sources, with the most prolific source being the health and safety industry monthly publications, The Safety and Health Practitioner: Institution of Safety and Health (1992 - 1999) and Safety Management: British Safety Council (1992 - 1999). Both publications provide reviews of accident at work cases, particularly those involving deaths at work. In addition to the two principal sources, personal communication, utilising health and safety industry sources, provided valuable data as well as updates. The Health and Safety Executive News Releases provided information on important cases prosecuted by the HSE. Other health and safety publications and law reports
combined with the media coverage of cases completed the information gathering profile.

The first database is identified in Table 6.1 *Cases considered for Manslaughter Prosecution* in Chapter 6. In all cases the name of the company or individual has been replaced by a code number to avoid potential complications with regard to the Data Protection Act. It was important to identify the year of the incident, the number of fatalities involved in each incident, the cause or location of incident, and the outcome in respect to manslaughter prosecution progress. It was decided to commence the database in 1992 to coincide with the introduction of the Management of Health and Safety at Work Regulations 1992. There was a different requirement for the second database which is identified in Table 6.4 *Cases of Deaths Due to Work and Financial Penalty*, in Chapter 6. As with the previous database all companies and individuals are given a code number. The number of fatalities in each incident, the year of the incident and the cause of death is included. The principal additions are the prosecution details to determine if the cases were prosecution under the Act, Regulations or a combination of both. The final piece of data was the outcome in terms of fines, if awarded. From these two database an evaluation can be undertaken to extrapolate information to provide overall outcomes. Those outcomes are shown in Chapter 6 and form the basis for the discussion in Chapter 7.
CHAPTER 6 - HISTORIC DATA ON FINES & DEATHS

Two databases have been developed for the project and the sources of the data are described in Chapter 5. The first database focuses on the manslaughter prosecution cases while the second database focuses on cases of deaths arising from work activities, with the resultant financial penalty.

6.1 CASES CONSIDERED FOR MANSLAUGHTER PROSECUTION

The representative data sample in Table 6.1 commences in 1992, to correspond with the introduction of the Management of Heath and Safety at Work Regulations 1992 (HSE 1992). A total of 87 cases are described, where it is alleged that the CPS have considered, taken or rejected a prosecution for manslaughter, based upon unofficial information available.

Each case has been assigned a code number as opposed to a company or individual name. The year and number of deaths are provided together with brief details of the incident itself. For example, 'employee - roof fall', indicates that a worker was in an unsafe situation and fell to his death. 'Carbon monoxide' is where there has been a failure by a gas fitter and/or a landlord to ensure safety compliance for gas appliances. The status shows whether a manslaughter case was progressed, dismissed by the courts after proceedings were progressed, or withdrawn by the CPS who decided not to continue or the defendant either pleaded or was found guilty. There are a number of cases which are identified as being considered by the CPS for a manslaughter prosecution, and remain as 'considered' as no further information was available.

Note: No Manslaughter = no case for manslaughter was progressed
Dismissed = is where a case reached court but was dismissed by the Judge
Not Known = is where information was unobtainable
Consider = is where the CPS is considering the prosecution of a case
Not Guilty = is where the defendant is found not guilty (either corporation or individual)
Guilty = is where the defendant, either corporation or individual is found guilty by the court

Table 6.1 CASES CONSIDERED FOR MANSLAUGHTER PROSECUTION

<table>
<thead>
<tr>
<th>CODE</th>
<th>YEAR</th>
<th>STATUS</th>
<th>FATAL</th>
<th>INCIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Worker - Heart attack</td>
</tr>
<tr>
<td>102</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Hospital Death</td>
</tr>
<tr>
<td>103</td>
<td>92/93</td>
<td>Dismissed</td>
<td>1 death</td>
<td>Public - Gas explosion</td>
</tr>
<tr>
<td>104</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>5 deaths</td>
<td>Chemical plant</td>
</tr>
<tr>
<td>105</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Electrocution</td>
</tr>
<tr>
<td>106</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>2 Deaths</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>107</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>2 Deaths</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>108</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Employee - roof fall</td>
</tr>
<tr>
<td>109</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>110</td>
<td>92/93</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Airport employee</td>
</tr>
<tr>
<td>111</td>
<td>92/93</td>
<td>Dismissed</td>
<td>1 death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>112</td>
<td>92</td>
<td>Dismissed</td>
<td>2 deaths</td>
<td>Demolition workers</td>
</tr>
<tr>
<td>113</td>
<td>93</td>
<td>No Manslaughter</td>
<td>1 death</td>
<td>Fall - Lift shaft</td>
</tr>
<tr>
<td>114</td>
<td>93</td>
<td>Not Known</td>
<td>6 Deaths</td>
<td>Truck incident</td>
</tr>
<tr>
<td>115</td>
<td>93/94</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Stevedore killed</td>
</tr>
<tr>
<td>116</td>
<td>93/94</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Hospital</td>
</tr>
<tr>
<td>117</td>
<td>93/94</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Driver killed</td>
</tr>
<tr>
<td>118</td>
<td>93/94</td>
<td>Guilty</td>
<td>4 deaths</td>
<td>Canoe</td>
</tr>
<tr>
<td>No.</td>
<td>Year</td>
<td>Charge</td>
<td>No. of Deaths</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>--------</td>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>119</td>
<td>93/94</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Employee death</td>
</tr>
<tr>
<td>120</td>
<td>94</td>
<td>Not Known</td>
<td>2</td>
<td>Driver + passenger</td>
</tr>
<tr>
<td>121</td>
<td>94/95</td>
<td>Dismissed</td>
<td>1</td>
<td>Electric shock</td>
</tr>
<tr>
<td>122</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>2</td>
<td>Building Collapse</td>
</tr>
<tr>
<td>123</td>
<td>94/95</td>
<td>Guilty</td>
<td>1</td>
<td>Employee</td>
</tr>
<tr>
<td>124</td>
<td>94/95</td>
<td>Not guilty</td>
<td>1</td>
<td>Employee burnt</td>
</tr>
<tr>
<td>125</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Nine year old boy</td>
</tr>
<tr>
<td>126</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>1</td>
<td>No information</td>
</tr>
<tr>
<td>127</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Employee</td>
</tr>
<tr>
<td>128</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Employee crushed</td>
</tr>
<tr>
<td>129</td>
<td>94</td>
<td>No Manslaughter</td>
<td>2</td>
<td>Boiling water</td>
</tr>
<tr>
<td>130</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Employee crushed</td>
</tr>
<tr>
<td>131</td>
<td>94/95</td>
<td>No Manslaughter</td>
<td>6</td>
<td>Members of public</td>
</tr>
<tr>
<td>132</td>
<td>94/95</td>
<td>Guilty</td>
<td>1</td>
<td>Carbon monoxide</td>
</tr>
<tr>
<td>133</td>
<td>94/95</td>
<td>Withdrawn</td>
<td>1</td>
<td>Fall</td>
</tr>
<tr>
<td>134</td>
<td>94/95</td>
<td>Withdrawn</td>
<td>1</td>
<td>Diver killed</td>
</tr>
<tr>
<td>135</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Employee killed</td>
</tr>
<tr>
<td>136</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Tractor</td>
</tr>
<tr>
<td>137</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>4</td>
<td>Building collapse</td>
</tr>
<tr>
<td>138</td>
<td>95</td>
<td>Consider</td>
<td>2</td>
<td>Construction</td>
</tr>
<tr>
<td>139</td>
<td>96</td>
<td>Guilty</td>
<td>6</td>
<td>Fishing vessel</td>
</tr>
<tr>
<td>140</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Scaffolder</td>
</tr>
<tr>
<td>141</td>
<td>95/96</td>
<td>Not Guilty</td>
<td>1</td>
<td>Diver killed</td>
</tr>
<tr>
<td>142</td>
<td>95/96</td>
<td>Consider</td>
<td>2</td>
<td>Platform collapse</td>
</tr>
<tr>
<td>143</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>144</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1</td>
<td>Elderly person</td>
</tr>
<tr>
<td>145</td>
<td>95/96</td>
<td>Charges</td>
<td>1</td>
<td>Train driver killed</td>
</tr>
<tr>
<td>Case No.</td>
<td>Year</td>
<td>Verdict</td>
<td>Details</td>
<td>Cause of Death</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
<td>-----------</td>
<td>--------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>146</td>
<td>95</td>
<td>Not Known</td>
<td>1 Death</td>
<td>Young girl - hospital</td>
</tr>
<tr>
<td>147</td>
<td>95</td>
<td>Not Known</td>
<td>2 Deaths</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>148</td>
<td>96/97</td>
<td>Not Guilty</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>149</td>
<td>96/97</td>
<td>Consider</td>
<td>1 Death</td>
<td>Paper bailing machine</td>
</tr>
<tr>
<td>150</td>
<td>96/97</td>
<td>Not Guilty</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>151</td>
<td>97/98</td>
<td>Not Guilty</td>
<td>1 Death</td>
<td>Train passenger</td>
</tr>
<tr>
<td>152</td>
<td>95/96</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Building collapse</td>
</tr>
<tr>
<td>153</td>
<td>96/97</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>7 year old killed</td>
</tr>
<tr>
<td>154</td>
<td>96/97</td>
<td>Consider</td>
<td>1 Death</td>
<td>Crushed</td>
</tr>
<tr>
<td>155</td>
<td>96/97</td>
<td>Guilty</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>156</td>
<td>97/98</td>
<td>Withdrawn</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>157</td>
<td>96/97</td>
<td>Not Guilty</td>
<td>1 Death</td>
<td>13 year old electric</td>
</tr>
<tr>
<td>158</td>
<td>95/96</td>
<td>Guilty</td>
<td>1 Death</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>159</td>
<td>96/97</td>
<td>Charges</td>
<td>1 Death</td>
<td>Boiler failed</td>
</tr>
<tr>
<td>160</td>
<td>97/98</td>
<td>Charges</td>
<td>1 Death</td>
<td>Slaughter gun</td>
</tr>
<tr>
<td>161</td>
<td>97/98</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Dangerous gas work</td>
</tr>
<tr>
<td>162</td>
<td>96/97</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Young employee</td>
</tr>
<tr>
<td>163</td>
<td>96/97</td>
<td>No Manslaughter</td>
<td>2 Deaths</td>
<td>Council workers</td>
</tr>
<tr>
<td>164</td>
<td>96</td>
<td>Consider</td>
<td>1 Death</td>
<td>Fall between train</td>
</tr>
<tr>
<td>165</td>
<td>96</td>
<td>Not Guilty</td>
<td>1 Death</td>
<td>Rail crash</td>
</tr>
<tr>
<td>166</td>
<td>97/98</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>No details</td>
</tr>
<tr>
<td>167</td>
<td>97/98</td>
<td>Charges</td>
<td>1 Death</td>
<td>Electrocution</td>
</tr>
<tr>
<td>168</td>
<td>97/98</td>
<td>Consider</td>
<td>1 Death</td>
<td>87 year old resident</td>
</tr>
<tr>
<td>169</td>
<td>97</td>
<td>Consider</td>
<td>1 Death</td>
<td>9 year old boy</td>
</tr>
<tr>
<td>170</td>
<td>96/97</td>
<td>Consider</td>
<td>1 Death</td>
<td>Fall from ladder</td>
</tr>
<tr>
<td>171</td>
<td>97/98</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Explosion - road tanker</td>
</tr>
<tr>
<td>172</td>
<td>97</td>
<td>No Manslaughter</td>
<td>1 Death</td>
<td>Boy 9 years dragged</td>
</tr>
</tbody>
</table>
A summary of the data presented in Table 6.1 is shown in Table 6.2 which focuses on the number of cases and their outcome.

Table 6.2 Summary of manslaughter cases.

<table>
<thead>
<tr>
<th>No</th>
<th>STATUS</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>were not progressed by the CPS to prosecution</td>
<td>(No Mansl)</td>
</tr>
<tr>
<td>7</td>
<td>were prosecuted by CPS and found guilty</td>
<td>(Guilty)</td>
</tr>
<tr>
<td>9</td>
<td>were prosecuted by CPS and found not guilty</td>
<td>(Not Guilty)</td>
</tr>
<tr>
<td>3</td>
<td>were considered for prosecution by the CPS but were withdrawn prior to trial</td>
<td>(Withdrawn)</td>
</tr>
<tr>
<td>5</td>
<td>were prosecuted by the CPS but were dismissed by the</td>
<td>(Dismissed)</td>
</tr>
</tbody>
</table>

93
Table 6.3, summarises the number of cases submitted to the CPS by year and the outcome. Apart from 1993/94 the number of potential cases are consistent between 14 and 16 cases.

Table 6.3 CASES SUBMITTED TO THE CPS FOR MANSLAUGHTER BY YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>1992/93</th>
<th>1993/94</th>
<th>1994/95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>14 cases submitted</td>
<td>6 cases submitted</td>
<td>14 cases submitted</td>
</tr>
<tr>
<td>Progressed</td>
<td>10 not progressed</td>
<td>4 not progressed</td>
<td>8 not progressed</td>
</tr>
<tr>
<td>Dismissed</td>
<td>3 were dismissed</td>
<td>1 guilty verdict</td>
<td>2 guilty verdict</td>
</tr>
<tr>
<td>Not Known</td>
<td>1 not known</td>
<td>1 not guilty</td>
<td>1 not guilty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 dismissed</td>
</tr>
<tr>
<td>1995/96</td>
<td>16 cases submitted</td>
<td>16 cases submitted</td>
<td>14 cases submitted</td>
</tr>
<tr>
<td>Progressed</td>
<td>6 not progressed</td>
<td>5 not guilty</td>
<td>6 not progressed</td>
</tr>
<tr>
<td>Considered</td>
<td>4 being considered</td>
<td>5 being considered</td>
<td>3 charged</td>
</tr>
<tr>
<td>Verdict</td>
<td>2 guilty verdict</td>
<td>3 not progressed</td>
<td>2 being considered</td>
</tr>
<tr>
<td>Known</td>
<td>2 not known</td>
<td>2 charged</td>
<td>2 not guilty</td>
</tr>
<tr>
<td>Guilty</td>
<td>1 not guilty</td>
<td>1 guilty verdict</td>
<td>1 not guilty</td>
</tr>
<tr>
<td>Verdict</td>
<td>1 charged</td>
<td></td>
<td>1 withdrawn</td>
</tr>
<tr>
<td>1998/99</td>
<td>7 cases submitted</td>
<td>2 being considered</td>
<td>6 not progressed</td>
</tr>
<tr>
<td>Considered</td>
<td>2 charged</td>
<td>3 charged</td>
<td>2 being considered</td>
</tr>
<tr>
<td>Verdict</td>
<td>1 guilty verdict</td>
<td>2 not guilty</td>
<td>2 not guilty</td>
</tr>
<tr>
<td></td>
<td>1 not progressed</td>
<td>1 not guilty</td>
<td>1 withdrawn</td>
</tr>
<tr>
<td></td>
<td>1 Dismissed</td>
<td></td>
<td>1 Dismissed</td>
</tr>
</tbody>
</table>
Notes: 1) 1998/99 is not complete

2) Cases identified as 'being considered' represent cases where some form of potential action was possible but no further information is available.

Expected Outcome:

If the basis of determining which cases should be progressed is founded on the present legal status of manslaughter, both individual and corporate manslaughter, then the terms of the proposed offence of corporate killing should mean a substantial increase in the number of cases that are considered and progressed for manslaughter. It is also evident that the prosecution of individuals, such as shown in carbon monoxide cases, is more easily progressed. The identification is against an individual as opposed to identifying a particular director or senior manager for corporate manslaughter.

6.2 DEATHS DUE TO WORK AND PROSECUTIONS

Table 6.4 presents those cases where a fatality occurred at work but the CPS did not pursue a manslaughter case, leaving the HSE to prosecute under health and safety legislation. Each case has been assigned a code number to replace the corporate or individual name. The year identifies the incident/prosecution period. Status, shows the level of fine levied against the corporation. The number of deaths for each case is followed by the charges prosecuted. The final column provides basic information for the cause of the fatal incident.
<table>
<thead>
<tr>
<th>Code</th>
<th>Year</th>
<th>Status</th>
<th>Fatal</th>
<th>Reg No</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>201</td>
<td>96/97</td>
<td>W'drawn</td>
<td>1</td>
<td>HSWA</td>
<td>Fatal accident to floor screeders labourer who fell into paddle mixer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£2500 fine</td>
<td></td>
<td>s3(1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Const</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REGS</td>
<td></td>
</tr>
<tr>
<td>202</td>
<td>96/97</td>
<td>£3500 fine</td>
<td>1</td>
<td>REGS</td>
<td>Electrocution.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£3500 fine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>203</td>
<td>96/97</td>
<td>No fine</td>
<td>1</td>
<td>HSWA</td>
<td>Tipper reversed through a development site without a bankman and site operative was hit and killed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>s3(1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>s2(1)</td>
<td></td>
</tr>
<tr>
<td>204</td>
<td>96/97</td>
<td>£10,000</td>
<td>1</td>
<td>HSWA</td>
<td>Roofing operative fatally injured after falling 10m through fragile roof light. No training or supervision. Client thought safety harnesses used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td>s2(1)</td>
<td></td>
</tr>
<tr>
<td>205</td>
<td>97/98</td>
<td>No fine</td>
<td>1</td>
<td>CDM</td>
<td>Contractor died when fell from structure whilst erecting. Designers of industrial racking system charged.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REGS</td>
<td></td>
</tr>
<tr>
<td>206</td>
<td>96/97</td>
<td>£10,000</td>
<td>1</td>
<td>HSWA</td>
<td>Man crushed between mast and cab of FLT whilst attempting to empty waste bin into waste skip.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td>s2(1)</td>
<td></td>
</tr>
<tr>
<td>207</td>
<td>96/97</td>
<td>£15,000</td>
<td>1</td>
<td>HSWA</td>
<td>Employee killed when cleaning machinery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td>s2</td>
<td></td>
</tr>
<tr>
<td>208</td>
<td>96/97</td>
<td>£4000</td>
<td>1</td>
<td>REGS</td>
<td>Fatal accident</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td></td>
<td>Accident inside a tumble drier which was part of a new batch of washing machines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£12,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td>£8000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£5000</td>
<td></td>
</tr>
<tr>
<td>209</td>
<td>96/97</td>
<td>£100K</td>
<td>1</td>
<td>HSWA</td>
<td>Employee's head was crushed between steel lifting beam and a feeder frame in factory. Failure of safety procedures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fine</td>
<td></td>
<td>s2(1)</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Fine</td>
<td>Accidents/Injuries</td>
<td>Employer</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>------</td>
<td>--------------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>210</td>
<td>97/98</td>
<td>£5000</td>
<td>1 Death</td>
<td>HSWA s2(1)</td>
<td>Employee fatally injured when run over by reversing front loading shovel machine in waste transfer station. No safe system of work.</td>
</tr>
<tr>
<td>211</td>
<td>97/98</td>
<td>£15,000</td>
<td>1 Death</td>
<td>HSWA s2(1)</td>
<td>Employee sustained fatal head injury from fall from height from the racking in a cold store.</td>
</tr>
<tr>
<td>212</td>
<td>96/97</td>
<td>£18,000</td>
<td>1 Death</td>
<td>HSWA s2(1)</td>
<td>Employee killed by crushing in conveyor belt at packaging co. Warned by insurance CO - no safe system of work.</td>
</tr>
<tr>
<td>213</td>
<td>97/98</td>
<td>W'drawn</td>
<td>1 Death</td>
<td>HSWA s2(1)</td>
<td>Fatal accident. No risk assessment carried out for work on MVR and no safe systems of work.</td>
</tr>
<tr>
<td>214</td>
<td>96/97</td>
<td>W'drawn</td>
<td>1 Death</td>
<td>FA s27 HSWA s2(1)</td>
<td>Man trapped by 3.5 tonne load which fell from 3 tonne crane due to unsafe system of work, lack of training and supervision.</td>
</tr>
<tr>
<td>215</td>
<td>96/97</td>
<td>£13,000</td>
<td>1 Death</td>
<td>HSWA s2(1) HSWA s6(1)</td>
<td>Drawstring of coat was caught up in a rotating shaft dragging him into diesel bowser</td>
</tr>
<tr>
<td>216</td>
<td>97/98</td>
<td>£375</td>
<td>4 x 4</td>
<td>Const HSW REGS</td>
<td>Subcontractor fell through single sheet roof light during factory re-roofing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£250</td>
<td>4 x 4</td>
<td>Const HSW REGS</td>
<td>Partner in industrial roofing and building supplies. In control of inexperienced sub contractor</td>
</tr>
<tr>
<td>217</td>
<td>96/97</td>
<td>£7000</td>
<td>1 Death</td>
<td>HSWA s3(1)</td>
<td>Fell approx 13 metres from ridge of roof whilst preparing to move leading edge protection. Only single handrail. Not wearing safety harness.</td>
</tr>
<tr>
<td>218</td>
<td>97</td>
<td>£2000</td>
<td>1 Death</td>
<td>HSWA s2(1)</td>
<td>Elderly man scalded to death.</td>
</tr>
<tr>
<td>219</td>
<td>97/98</td>
<td>£13,500</td>
<td>1 Death</td>
<td>HSWA s3(1)</td>
<td>Employee killed by bale of flax which fell from hoist during lifting operation. No safe system of work.</td>
</tr>
<tr>
<td>No</td>
<td>Year</td>
<td>Fine</td>
<td>No of Deaths</td>
<td>CA Section</td>
<td>Cause of Death</td>
</tr>
<tr>
<td>-----</td>
<td>-------</td>
<td>-------</td>
<td>--------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>221</td>
<td>96/97</td>
<td>£12,000</td>
<td>1</td>
<td>HSWA s2</td>
<td>Co failed to maintain a ladder which resulted in a fatality</td>
</tr>
<tr>
<td>222</td>
<td>96/97</td>
<td>£15,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Fall of a 17 year old untrained roofer at major construction site. Failure to train and supervise - unsafe system of work.</td>
</tr>
<tr>
<td>223</td>
<td>96/97</td>
<td>£15,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>General foreman on large engineering job killed by falling lighting column. Unsafe system of work.</td>
</tr>
<tr>
<td>224</td>
<td>96/97</td>
<td>£60,000</td>
<td>1</td>
<td>Const REGS</td>
<td>1 employee killed and 1 injured following collapse of bridge being underpinned.</td>
</tr>
<tr>
<td>225</td>
<td>97/98</td>
<td>No fine</td>
<td>1</td>
<td>HSWA s3(1)</td>
<td>Fatal accident to 7 year old child who drowned in public swimming pool. Inadequate life guard supervision.</td>
</tr>
<tr>
<td>226</td>
<td>96/97</td>
<td>£2500</td>
<td>1</td>
<td>HSWA s3(2)</td>
<td>Roofer electrocuted on farm when repairing barn roof, cladding and internal wiring.</td>
</tr>
<tr>
<td>227</td>
<td>96/97</td>
<td>£500</td>
<td>1</td>
<td>HSWA s3(1)</td>
<td>2 year old child crushed by falling hopper.</td>
</tr>
<tr>
<td>228</td>
<td>97/98</td>
<td>£10,000</td>
<td>1</td>
<td>HSWA s3(1)</td>
<td>Fatal accident of crane driver caused by falling facing stone brick. Failure to provide adequate access and safe system of work for gaining access to building.</td>
</tr>
<tr>
<td>229</td>
<td>96/97</td>
<td>£12,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Forklift truck struck work piece causing it to topple and trap welder.</td>
</tr>
<tr>
<td>230</td>
<td>96/97</td>
<td>£7000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Employee killed attempting to clear misfeed on machine from within interlocked enclosure.</td>
</tr>
<tr>
<td>231</td>
<td>96/97</td>
<td>£32,500</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Fatal accident of employee caused by using unsafe procedures.</td>
</tr>
<tr>
<td>232</td>
<td>96/97</td>
<td>£2500</td>
<td>1</td>
<td>REGS</td>
<td>15 year old fell through roof.</td>
</tr>
<tr>
<td>233</td>
<td>96/97</td>
<td>£15,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Unsecured stacking of steel tubes fell on 2 employees killing one.</td>
</tr>
<tr>
<td>Case</td>
<td>Year</td>
<td>Details</td>
<td>Violation</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>---------</td>
<td>-----------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>234</td>
<td>97/98</td>
<td>Painter fell 35 feet sustaining severe injuries.</td>
<td>HSWA s2(1)</td>
<td>HSWA s3(1) REGS</td>
<td></td>
</tr>
<tr>
<td>235</td>
<td>96/97</td>
<td>£2000 Employee - roof fall</td>
<td>HSWA s2(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>236</td>
<td>96/97</td>
<td>£10,000 Employee entangled around take up shaft at company cloth inspection frame. Unsafe system.</td>
<td>HSWA s2(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>237</td>
<td>98</td>
<td>Two rail workers struck by train at Ebbw Junction, Newport, South Wales.</td>
<td>HSWA s2(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>238</td>
<td>96/97</td>
<td>£15,000 A driller fell from a 14m face and received fatal injuries</td>
<td>HSWA s2(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239</td>
<td>97/98</td>
<td>£2500 Fatal accident. PR submitted but awaiting outcome of inquest before proceeding.</td>
<td>HSWA s2(1) REGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>240</td>
<td>96/97</td>
<td>£12,000 Elderly patient scalded.</td>
<td>HSWA s3(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>241</td>
<td>96/97</td>
<td>£15,000 Subcontractor killed when he fell 11m through fragile roof light. Previous breaches of H &amp; S.</td>
<td>HSWA s3(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>242</td>
<td>98</td>
<td>Maintenance team member struck by train. Unsafe system of work.</td>
<td>HSWA s3(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>243</td>
<td>97/98</td>
<td>£3000 Driver with steel stockholding company killed when manually unloading steel beams. Previous advice not acted on. Culpability of managers/directors considered but not pursued.</td>
<td>HSWA s2(1) REGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Year</td>
<td>Fine Amount</td>
<td>Deaths</td>
<td>Authority</td>
<td>Cause of Death</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>-------------</td>
<td>--------</td>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td>244</td>
<td>96/97</td>
<td>£1000</td>
<td>1</td>
<td>REGS</td>
<td>Prosecutions for breaches which were contributory factors but not directly related to accident</td>
</tr>
<tr>
<td>245</td>
<td>96/97</td>
<td>£3000</td>
<td>1</td>
<td>MHSW REG 3</td>
<td>Fatal accident to employee scalded by release of hot water from man access door on flash vessel of Evaporator Plant.</td>
</tr>
<tr>
<td>246</td>
<td>96/97</td>
<td>£2500</td>
<td>1</td>
<td>Docks REGS</td>
<td>Sevedore killed by load of 5 steel sections which dropped after two webbing slings failed.</td>
</tr>
<tr>
<td>247</td>
<td>96/97</td>
<td>£7,500</td>
<td>1</td>
<td>HSWA s3(1)</td>
<td>Unsaferly secured construction material fell on a child. Mother and child were not given danger warning.</td>
</tr>
<tr>
<td>248</td>
<td>96/97</td>
<td>£20,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Employee sustained fatal crash injuries when fell into waste paper baler. No safe systems.</td>
</tr>
<tr>
<td>249</td>
<td>97/98</td>
<td>£10,000</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Employee killed when he fell from top of road tanker.</td>
</tr>
<tr>
<td>250</td>
<td>96/97</td>
<td>£2000</td>
<td>1</td>
<td>REGS</td>
<td>Fatal accident at drying cylinder of an envelope machine. Man trapped by head.</td>
</tr>
<tr>
<td>251</td>
<td>96/97</td>
<td>£12,500</td>
<td>1</td>
<td>HSWA s2(1)</td>
<td>Employee drowned. No life jacket supplied. No safety equipment supplied. No safe system of work.</td>
</tr>
<tr>
<td>252</td>
<td>96/97</td>
<td>£5000</td>
<td>1</td>
<td>HSWA s3</td>
<td>Steeplejack fall</td>
</tr>
<tr>
<td>253</td>
<td>98</td>
<td>£5000</td>
<td>1</td>
<td>HSWA s2</td>
<td>Steeplejacks</td>
</tr>
<tr>
<td>254</td>
<td>98</td>
<td>£25,000</td>
<td>1</td>
<td>HSWA</td>
<td>Killed by lorry</td>
</tr>
<tr>
<td>255</td>
<td>98</td>
<td>£16,000</td>
<td>1</td>
<td>HSWA</td>
<td>Trench collapse</td>
</tr>
</tbody>
</table>
The ways in which the 63 cases, all of which involved a death at or due to work, were progressed through the legal system are summarised in Table 6.5. The court history of each case has not been reviewed, and therefore no judgement can be made in respect to the variance in the levels of penalty imposed against the charge, but the data base does highlight considerable differences in the level of financial penalties. The summary shows the average fines for the charges laid. The combined HASAWA eg; Section 2 + Section 3 cases obtained higher overall fines. Cases that were progressed under HASAWA Section 2 received middle range fines and HASAWA s3 cases received considerably lower fines.

Table 6.5 SUMMARY OF PROSECUTIONS.

<table>
<thead>
<tr>
<th>No</th>
<th>STATUS</th>
<th>CHARGES</th>
<th>FINE AVGE £</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>cases were charged under</td>
<td>Section 2 HASAWA</td>
<td>17,580</td>
</tr>
</tbody>
</table>
Table 6.6 shows the overall distribution of fines levied. One case received a financial penalty of a fine of £150,000. There were only nine cases that received fines in excess of £20,000. Twenty five cases received fines of between £10,000 - £20,000, and nine cases between £5,000 and £10,000, and there were fourteen cases where the fine was below £5000. In three cases there were no fines and in one case the outcome was not known.

Table 6.6 SUMMARY OF FINES

<table>
<thead>
<tr>
<th>No</th>
<th>Status</th>
<th>Fine = £</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>received financial penalty = £</td>
<td>150,000</td>
</tr>
<tr>
<td>1</td>
<td>received financial penalty = £</td>
<td>110,000</td>
</tr>
<tr>
<td>1</td>
<td>received financial penalty = £</td>
<td>100,000</td>
</tr>
<tr>
<td>1</td>
<td>received financial penalty = £</td>
<td>60,000</td>
</tr>
<tr>
<td>1</td>
<td>received financial penalty = £</td>
<td>50,000</td>
</tr>
</tbody>
</table>
It does not follow that the HSE will prosecute in every case of a fatality because, as discussed previously, there are a number of factors that are drawn into the decision. If the HSE prosecutes it can only be under Health and Safety legislation and will result in fines being imposed, where defendants are found guilty as defined in the legislation. Cases that the HSE consider to be very serious breaches of health and safety legislation can be referred to the Crown Prosecution Service for consideration for manslaughter.

Table 6.7 identifies the number and penalties of all (fatal and non-fatal) prosecutions undertaken by the HSE for the period 1993/94 to 1997 (HSC, 1998). It is important to note that there is no separation for cases where a death was involved.
Table 6.7  PROSECUTIONS BY HSE 1993/94 - 1997/98 (HSC, 1998)

<table>
<thead>
<tr>
<th></th>
<th>Information's Laid</th>
<th>Cases leading to conviction</th>
<th>Average penalty per conviction £</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993/94</td>
<td>1,793</td>
<td>1,507</td>
<td>£3,103(1)</td>
</tr>
<tr>
<td>1994/95</td>
<td>1,803</td>
<td>1,499</td>
<td>£2,873(2)</td>
</tr>
<tr>
<td>1995/96</td>
<td>1,767</td>
<td>1,451</td>
<td>£2,752</td>
</tr>
<tr>
<td>1996/97</td>
<td>1,490</td>
<td>1,195</td>
<td>£5,421(3)</td>
</tr>
<tr>
<td>1997/98</td>
<td>1,654</td>
<td>1,268</td>
<td>£4,785(4)</td>
</tr>
</tbody>
</table>

Notes:

1) Includes three individual fines of £250,000 and single fines of £150,000 and £100,000. The average fine for 1993/94 without these convictions was £2447.

2) Includes two individual fines of £200,000 and £100,000. If these convictions are excluded, the average fine for 1994/95 was £2677.

3) Includes four separate fines of £750,000, £500,000, £250,000 and £200,000; fines totalling £400,000 against one company; two individual fines of £100,000 and one fine of £125,000. If these convictions are excluded, the average fine for 1996/7 was £3113.

4) Includes two fines of £100,000, one fine of £170,000, two fines of £150,000, one fine of £100,000, one of £150,000, one of £100,000. If these convictions are excluded, the average fine for 1997/98 was £3886.

This Chapter has provided the two databases developed for manslaughter cases and deaths at work cases with resulting fines. Balanced against the official statistics the databases provide more detail for research purposes and while there will be some variance in the accuracy by the nature of the method used to obtain the information, the two databases and the information they reveal, provide a foundation for discussion and further research.
CHAPTER 7 - DISCUSSION AND CONCLUSIONS

The research undertaken in the study is divided into two parts. The first part is a review of the background to corporate manslaughter cases, to include those that were successful and those that were not. This involved an examination of the prosecution of a small company, balanced against the unsuccessful prosecution of a large company. The second part of the project required the establishment of a data profile, and that required the establishment and evaluation of two databases. One database reviews cases where the focus is on corporate manslaughter, while the second database reviews cases where there were deaths at work but no manslaughter prosecutions. However, enforcement actions were taken for health and safety offences, resulting in fines being levied.

7.1 DISCUSSION

The literature search focused initially on the Law Commissions Report 237 (1996) which examined the current situation in respect to the offences of manslaughter. The report continued to examine manslaughter in the corporate aspect and provided recommendations resulting in the proposal for a new offence of Corporate Killing. There are a number of commentators on the subject who include Clarkson (1996), Wells (1993), Bergman (1999), Slapper (1992) and Gobert (1994) who add to the debate both for and against the proposed offence. The Sheen report (1987) provides valuable information in respect to management failure and the inability to obtain a conviction against a large corporation for corporate manslaughter under the present law. A number of documents issued by HMSO, the HSC and the HSE are referred to for the legal requirements and industry practice in respect to health and safety at
work. Throughout the study legal commentary is reported relating to case issues or outcomes, to identify successes and failures on specific points of law.

The study examines the basis of current law manslaughter and corporate manslaughter and the proposed new offence of Corporate Killing. In support of this the literature search quotes commentators on cases that were not progressed for corporate manslaughter but were dealt with for health and safety offences and shows the resulting fines. The search identifies that there was no substantive evidence in the form of data that would provide basic information of case profiles for the study to evaluate, and therefore two databases were developed, one to review manslaughter at work cases, the other to review health and safety legislation prosecutions that required the development of a data gathering process.

The manslaughter database provides valuable evidence in that of 87 cases reviewed for possible manslaughter at work charges, both corporate and individual (Table 6.2), only 7 cases returned guilty verdicts, and only 3 of those were corporations. The three successful manslaughter cases were against small ‘one man’ type organisations, 

*Peter Kite and OLL Ltd* (Knight 1994), *Jackson Transport (Ossel/) Ltd* (Jolliffe 1996) and *Bowels Transport Ltd* (Leatherly 1999). The remaining four were cases of individuals who caused death through work, and are not examined in detail as the focus of the study is on corporations. Because of the problems in identifying an ‘individual’ in control of a corporation, and because of the need to establish gross negligence, there were 9 cases that were committed to trial which received not guilty verdicts, and 5 cases were dismissed by the courts. The study identifies that 12 cases were under consideration by the CPS, but this figure is not quantified as to progress due to lack of available information. The evaluation of the database concludes from the evidence that the number of cases progressed for manslaughter at work prosecution, when balanced against successful outcomes is extremely low. The principal reason for the low figure is explained by the problems faced with prosecuting any corporation for the serious offence of manslaughter. The prosecution details of each case in the databases are not known, therefore the study makes no detailed evaluation of the database outcomes, particularly those cases that were
unsuccessful. In the annual profile (Table 6.2) of cases submitted for consideration in the year 1993/94 there are 6 cases identified which is less than half of the other years and there is no explanation for the low figures.

The cases of deaths due to work activity and financial penalty (Table 6.4) database encompasses the cases where there was a death at or due to work, and while there was not a manslaughter prosecution, charges were made by the HSE under health and safety offences, with resulting outcomes ranging from fines to no penalty. In the summary of prosecutions (Table 6.5) the profile shows the breakdown into how many cases there were and which offence or combination of offences each case was charged with. As discussed previously, fines in the Magistrates’ Court for some Health and Safety at Work Act offences have a maximum penalty of £20,000 with the remaining HASAWA Act offence and breaches of Regulation having a maximum penalty of £5,000. Fines for all health and safety offences are unlimited in the Crown Court. The research did not determine whether the case was heard in the Magistrates’ Court or the Crown Court, however the penalties in excess may indicate those cases heard in the higher court. The study revealed that the four cases that were charged with more than one Health and Safety at Work Act offence received considerably greater fines. There were four cases where the charges are unspecified but the fines are considerable. The data obtained for cases of deaths due to work and financial penalty (Table 6.6), provide a graphic overview of the variance in financial penalties imposed upon a variety of corporations and individuals for deaths at work prosecutions. Fines for offences under the Health and Safety at Work Act where there was a death identified the highest fine of £150,000, but showed that only 12 cases attracted fines in excess of £20,000. There were 24 cases within the £10 - 20,000 range, 9 cases within the £5 - 10,000 range and 14 cases attracted fines below £5,000. This data identifies a large variance between the maximum and minimum level of fine with no meaningful explanation. It further shows that one substantial fine in a given year can dramatically increase the overall annual penalty statistics for that year.
There are explanations from individuals and organisations such as that quoted by Bergman (1999) who identifies that only one study has been undertaken in reviewing the level of fines when balanced against the wealth of the company. He states:

"The West Midlands Health and Safety Advice Centre obtained information on the annual profits of 65 of the 260 companies sentenced in the region between 1987 and 1993. The five companies with average profits of between £1-10,000 received an average fine of £750 per offence - 16 per cent of their profits. Companies with profits of between £100-150,000 received fines of between £1290 per offence - 0.5 per cent of their profits. The five companies with profits of over £10 million received average fines of £1185, equivalent to 0.002 per cent of their profits."

Concerns about the level of fines were discussed by Davies (1996), Chairman of the Health and Safety Commission, who reviewed how Magistrates’ Courts reacted to health and safety cases. The key issue was addressed in the opening paragraph where he stated:

"Fines for health and safety offences are too low. Employers who cause injury, or even death, get off lightly. These are views which we hear from members of the public as well as the media. When prosecution and conviction follow, only the courts can decide penalties which send the right message: that risks to health and safety must be controlled. Experience shows that the size of the fine has an important impact on preventative work with firms. If a court rewards with low fine the good fortune of an employer whose crime did not result in injury or death, other employers may believe they can neglect health and safety with impunity."

The official statistics for average fines (Table 6.7, HSC 1998) for a five year period covering all convictions, both fatal and non-fatal, show the number of 'information's laid' (the prosecution process) followed by the cases that were progressed and led to a conviction. The outcome clearly shows that average fines for health and safety convictions are very low, and the study has identified this to be a major factor in health and safety cases. The number of cases progressed to the courts for Corporate Killing prosecutions, can be expected to increase substantially under the proposed
offence, compared with the number under the current law of manslaughter and the tenuous link to corporate manslaughter.

The study's objective is to examine the existing status of deaths at work and corporate manslaughter cases to evaluate the implications of the proposed new offence of Corporate Killing. This has been achieved through the evaluation of case histories, the development of two databases and their evaluation, with the outcome that by transferring culpability from the individual to the management, the result will allow for a substantial increase in prosecutions of corporations for the corporate offence.

7.2 CONCLUSIONS

The Health and Safety at Work etc Act 1974 (HMSO 1974) and the Management of Health and Safety at Work Regulations 1992 (HSE 1992) provide a clear requirement for employers to ensure the health and safety of those they employ and those who they do not, but who could be affected by their business activities. There is a legal requirement for companies employing more than 5 people, for there to be a written health and safety policy (HMSO 1974), which identifies the directors and their management function, and defines the general operation of the company with regard to health and safety. It should identify and define any specific hazards and risk controls that are established in respect to those particular activities. This does not mean that a company employing less than 5 persons will not be affected by the proposed offence. The safety policy is a high level document approved and signed by the chairman, managing director or chief executive. It defines the integration of an effective safety management system, so as to ensure that the corporate safety philosophy reaches every level of the businesses activities, and ensures management feedback of the procedure's effectiveness. This then means that the 'controlling minds' are responsible and accept ownership of an effective health and safety culture, and have knowledge of safety issues within their corporations. Larger corporations generally have a greater overall duty of care for more people, whether employed or not, and therefore the results of a failure in health and safety could be more serious. However, when addressing hazards, the size of a corporation becomes irrelevant as it
is the extent of the risks derived from those hazards that is the key factor and therefore, a small corporation involved in hazardous activities requires more effective management control of the risks. The study identifies that many deaths at work are the result of management failure or gross negligence, and this means that it can be anticipated that there will be an increase in manslaughter at work prosecutions.

The problem with the present law of manslaughter is the need to 'identify' an individual who was responsible for, or had knowledge of, the cause of a fatal injury at work and failed to take action. It is that anomaly that the Law Commission proposes to redress through the proposed offence of Corporate Killing, which involves the redefining the law of manslaughter. In broad terms the proposed offence removes the onus of failure or gross negligence from an individual and places it out the management an organisation. The outcome would be that large corporations would be tested for manslaughter through the legal process, where judge and jury can make judgement on the level of negligence and management failure. This process will alleviate the public perception that large corporations are getting away with failing to ensure the health and safety of people affected by their work activities.

The study has identified that the failures under the current law have been brought into the public arena through the media, pressure groups and trade unions, who have created a power lobby with the aim of seeing directors held accountable for their actions. Directors are seen to receive the rewards of their office, but when things go seriously wrong it is argued that directors hide within the corporate structure and therefore avoid culpability. Further concern is that the public sees individuals, generally employees, charged with manslaughter when the serious failings are at boardroom level and no action is levied against the directors, who remain outside the law. The failures are deemed to come from ineffective safety procedures, lack of training and competent staff, limited information and a poor culture of safety.

Two corporate manslaughter cases have been examined in detail. The first, was OLL Ltd and Peter Kite (Knight 1994) which involved a small 'one man' company and was a successful prosecution. The second, P & O European Ferries (Dover) Ltd (Sheen 1987) was the unsuccessful prosecution of a large corporation. It was evident
that with Kite, he had personal knowledge of safety failings, through previous warnings from former employees, including letters detailing the concerns. Even though he was not personally involved in the actual incident, it was his failure to act on information that held him culpable. In this case and that of Jackson and Jackson Transport Ltd (Jolliffe 1996) and Bowles Transport Ltd (Lethley 1999) it is clear as to who was found negligent and it meant that liability could be placed upon those in control of the company. However, the capsizing of the Herald of Free Enterprise prosecution failed in part because there was no one person who could be 'identified' as being responsible and negligent, as was required under the current law of manslaughter. In evaluating the process of the law v health and safety in the Herald case, the evidence shows senior management knew what was happening, but did not provide equipment or issue operating directives that would enhance safety, and had not learned from previous disasters. In the case of Great Western Trains Ltd (Towmey 1999) the driver did not see the red signal, but the management allowed the train to run when two safety systems were not working, which was a corporate safety culture problem.

The sanctions that are proposed against corporations which are found guilty under the offence of Corporate Killing are those of an unlimited fine, which are the same as for offences under the Health and Safety at Work etc Act (HMSO 1974). The argument from the pro-manslaughter lobby is that a fine may be inappropriate, and that for the offence to be taken seriously a custodial sentence should be available. That would mean directors and executives could be imprisoned for their failure to ensure health and safety. In this context, an individual director or executive of a corporation who has through negligence, failed to ensure effective and positive health and safety procedures and control risks could be culpable, placing the responsibility for health and safety where it should be, in the boardroom. The anti-manslaughter lobby provides the view that because the Health and Safety at Work etc Act offences have unlimited fines in the Crown Court there is no requirement to have the new offence, and prosecution for Corporate Killing is superfluous. It is further argued that it is impossible to have a situation where a director or executive can be imprisoned as the result of a death at work, and a company itself cannot be committed to prison. There
are other sanctions that could be considered including the disqualification of directors from holding office, the possibility of freezing the assets of a corporation at the commencement of an investigation, and that directors are fined as individuals. In the case of large corporations the possibility of sanctions against directors as individuals would be more effective than large fines against the corporation. The fact that corporations could have remedy orders made against them would also be effective, because this means that the failures in the system identified by the court would have to be corrected as part of the legal process. It is an important fact that even if a corporation is prosecuted under the corporate offence, individuals can still be prosecuted for manslaughter if deemed culpable.

Deaths at work are investigated by the Police to determine if there has been a criminal offence of negligence or foul play; however, the Police do not have skills for investigating industrial/work accidents, which is clearly the role of the Health and Safety Executive (HSE). HSE inspectors are conversant with health and safety legislation and are able undertake investigations into 'at work' accidents to identify the root cause. They have the powers to take enforcement action, including prosecutions and can initiate remedial action with the aim of preventing further accidents, and so increase standards and awareness of health and safety issues. Those cases where there has been serious negligence can be referred by the HSE to the Police or CPS for consideration for a manslaughter investigation and prosecution. In this situation the HSE and the Police undertake a joint investigation, reporting to the CPS, which makes the final decision of whether to prosecute for manslaughter, either against an individual or a corporation. The co-operation between the three organisations has not been consistent throughout England and Wales which had been the focus of condemnation by the pro manslaughter lobby. This has been rectified through the introduction of the Protocol for Liaison (HSE 1998) in death at work incidents, which provides for co-operation between the HSE, Police and the CPS.

In the final analysis of Corporate Manslaughter, the concern is that large organisations are exempt from prosecution for manslaughter at work. The failure of the cases against P & O European Ferries (Dover) Ltd curtailed further Corporate
Manslaughter cases, and caused consternation from those campaigning for sanctions to be imposed against companies and their directors for deaths at or through work. That was the position until the attempt by the Crown Prosecution Service (CPS) to progress a Corporate Manslaughter case against Great Western Trains Ltd (Towmey 1999) in July 1999, but that attempt also failed. The landmark ruling by Mr Justice Scott Baker means that no large organisation can be prosecuted for Corporate Manslaughter unless the proposed new offence of Corporate Killing is adopted into the law.

The outcomes of this study indicate that although there are limitations in the available evidence, the Health and Safety at Work etc Act 1974 (HMSO 1974) has in some cases failed to provide a high level of deterrence to ensure the health and safety of employees and those not employed in the event of deaths caused by corporations and in particular, large corporations, presenting the case for the new offence of Corporate Killing.

7.3 FURTHER RESEARCH

A key issue that has evolved from the manslaughter at work study is the question of punishment where a case is proven and a level of management failure determined. Commentators claim that fines have been available under the Health and safety at Work Act, where in the Crown Court, fines have been unlimited, but these alone have failed to stop serious incidents involving loss of life. A research project could review the question as to what sanctions could be adopted, including the option of custodial sentence for senior management, based upon the degree of negligence and determining those within the board of directors or executives who should be liable.

The focus of the new offence will be on management failure, and therefore further research could be undertaken to evaluate in detail the management failures involved in established corporate and individual manslaughter cases. The purpose would be to identify the root causes of the accidents and balance those outcomes against management failure as determined in the new offence. There have been a number of
accidents with large loss of life, and as identified within the study, no individual or corporate body has been held accountable. The evidence in those cases could be reviewed to determine the level of management failure, and whether under the draft Bill offence of Corporate Killing, those corporations could have faced manslaughter at work offences.
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Ibid, (1996h) p 82.


Ibid, (1996m) p 84.


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Twomey, J. (1999). No one can be charged for this carnage. *The Express, 3 July, p 9.*  


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Ibid, Chapter 2 (a) p 101.

Ibid, Chapter 2 (b) p41.

Ibid, Chapter 3 p128.

Ibid, Chapter 5 (a) p30.

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Ibid, Chapter 5 (c) p 34.

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APPENDIX 1

A PROTOCOL FOR LIAISON
WORK RELATED DEATHS

A protocol for liaison
Foreword

Foreword by Jenny Bacon CB, Director General, Health and Safety Executive

The Health and Safety Executive (HSE) fully endorses this protocol. We very much welcome the joint working between HSE, the Crown Prosecution Service and the Police that led to its development, and look forward to continued co-operation on putting it into practice. The protocol represents an important step forward in ensuring effective liaison between the enforcing and prosecuting authorities in relation to work-related deaths. The co-ordinated approach it describes and the arrangements it establishes for continuing liaison at national and local levels will help avoid any confusion that can arise because more than one authority is involved. More importantly, it will ensure that the timely decisions about prosecutions are taken on the basis of sound and thorough investigations.

Jenny Bacon CB
Director General, HSE
Foreword

Foreword by Dame Barbara Mills QC, Director of Public Prosecutions

This is an important initiative. The offences to which this protocol relate are sensitive and the public must be sure that there has been a thorough investigation of the case and that the decision to prosecute has been carefully considered by all agencies before an announcement is made.

The protocol acknowledges these concerns and establishes a structure for effective liaison between the three organisations at each stage of the case from investigation through to a prosecution before the courts.

The Crown Prosecution Service looks forward to taking this protocol forward in partnership with the Health and Safety Executive and police.

Dame Barbara Mills QC
Director of Public Prosecutions
Foreword

Foreword by David Phillips, QPM, BA (Econ), Chief Constable of Kent County Constabulary and Chairman of the Crime Committee of the Association of Chief Police Officers

The Crime Committee of the Association of Chief Police Officers fully endorses this protocol, which provides a broad framework within which the Health and Safety Executive, the Police and the Crown Prosecution Service can work together in cases involving death and life threatening injury associated with incidents which do not necessarily appear as homicides in the initial stages.

By following the procedures in this document, the agencies involved will ensure that an appropriate and thorough investigation is undertaken and that prosecution, where appropriate, is structured and unequivocal.

[Signature]

David Phillips
Chief Constable
Chair of ACPO Crime Committee
Introduction

This protocol has been agreed between the Health and Safety Executive (HSE), the Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS). It sets out the principles for effective liaison between the HSE, police forces and the CPS in relation to work-related deaths in England and Wales where HSE is the enforcing authority for health and safety legislation. In particular, it deals with incidents where evidence indicates that the crime of manslaughter or corporate manslaughter may have been committed.

The HSE, police and CPS have different roles and responsibilities in relation to a work-related death. The HSE is a statutory body responsible under section 18 of the Health and Safety at Work etc Act (HSWA) 1974 for making adequate arrangements for the enforcement of health and safety legislation with a view to securing the health, safety and welfare of workers and protecting others, principally the public. The HSE cannot investigate or prosecute for general criminal offences such as manslaughter.

Police forces have the responsibility to investigate crimes in general and recommend prosecution of offenders to the CPS. The police will also have an interest in establishing the circumstances surrounding a work-related death in order to assist the coroner’s inquest.

The CPS will review the evidence and decide if there is a realistic prospect of conviction and if so, whether a prosecution is justified in the public interest.

The underlying principles of this protocol are as follows:

- An appropriate decision concerning prosecution will be made based on a sound investigation of the circumstances surrounding work-related deaths.
- The police will conduct an investigation where there is an indication of manslaughter (or another serious general criminal offence).
- HSE will also investigate under the HSWA 1974 and pass information suggesting manslaughter on to the police or, where appropriate, the CPS.
- The decision to prosecute will be made by the CPS and HSE without undue delay and will take full account of the criteria set down in The Code for Crown Prosecutors. The HSE will also have regard to the principles of the Health and Safety Commission’s Enforcement Policy Statement.
- The prosecution decision will be co-ordinated.
- Bereaved families and witnesses will be kept suitably informed.
- The HSE, police and CPS will establish effective mechanisms for liaison.
- This protocol is available to the public.
1 INITIAL PROCEDURE

1.1 A police detective of supervisory rank should attend the scene of a work-related death, or where there is a strong likelihood of death resulting from an incident arising out of or in connection with work, and should:

(a) make an initial assessment about whether the circumstances might justify a charge of manslaughter, or other serious general criminal offence, in which case the police will commence their investigation (see clause 2.1);

(b) where the Health and Safety Executive (HSE) is the enforcing authority (see Annex A) confirm whether the employer, or other responsible person (eg the person in control of the premises at which, or in connection with the work at which, the incident occurred) has notified the death or injury to the HSE by the quickest practicable means; and

(c) liaise with the HSE inspector, or HSE duty officer if out of office hours and either:

(i) inform the HSE of the police decision to investigate; or

(ii) where the initial assessment indicates that there will be no police investigation, discuss arrangements for preserving the scene and the nature of the assistance that the police are able to provide to the HSE investigation.

2 INVESTIGATION

Police investigation

2.1 As a general guide, the police will investigate where there is evidence or a suspicion of deliberate intent or gross negligence or recklessness on the part of an individual or company rather than human error or carelessness.

2.2 The HSE will provide any agreed technical support to the police, and continue to investigate matters relating to possible offences under the Health and Safety at Work etc Act (HSWA) 1974. The HSE will not lay an information until the police and Crown Prosecution Service (CPS) have reached a prosecution decision.

2.3 The police and the HSE will liaise and agree arrangements for keeping relatives informed, dealing with media inquiries and making any public announcements.

HSE investigation

2.4 Where the police decide that a charge of manslaughter, or any other serious offence, cannot be justified, the HSE will continue with its own investigation.

2.5 Where there is an HSE investigation the police will, upon request, provide agreed local support.

2.6 Where, during the HSE investigation, evidence indicates an offence of manslaughter may have been committed, HSE will refer the matter to the police without delay. Where matters cannot be resolved after referral to the police, HSE Solicitor’s Office may refer the matter to the CPS.

2.7 Where there was an initial investigation by the police and the police indicate that they wish to retain an interest, the HSE shall notify police of the outcome of the inquiry and the nature of the charges preferred.

3 RETENTION AND DISCLOSURE OF MATERIAL OBTAINED DURING THE COURSE OF AN INVESTIGATION

3.1 Where there is a police investigation, material obtained during the course of the inquiry should be shared subject to any statutory restriction placed on HSE by the HSWA 1974. Agreement should also be reached as to which organisation will assume responsibility for the retention of exhibits.

3.2 The retention and disclosure of material in relation to manslaughter, health and safety or other prosecutions brought by the CPS shall be in accordance with the guidelines produced by the CPS.
4 SPECIAL INQUIRIES

4.1 In the case of some serious incidents, particularly those involving multiple fatalities, it may be appropriate for the investigations to be jointly managed. The Health and Safety Commission may also direct the HSE to investigate and produce a special report. Alternatively, the Commission may, with the consent of the Secretary of State, direct that a public inquiry be held.

4.2 In accordance with this protocol, the police will, upon request, provide the necessary support to the investigation. The police will also provide any material evidence requested by the person appointed by the Commission to conduct the public inquiry, subject to the provisions of the Health and Safety Inquiries (Procedure) Regulations 1975.

4.3 Reports relating to public inquiries and other major HSE investigations cannot generally be published until the conclusion of any criminal proceedings. In order that observations or recommendations about health and safety that are in the public interest can be disclosed and acted upon as soon as practicable, there should be no undue delay in taking the decision to prosecute and expediting proceedings thereafter.

5 ADVICE PRIOR TO CHARGE

5.1 The police should seek the advice of the CPS prior to charge where consideration is given to charging:

(a) an individual with manslaughter in a situation envisaged under the protocol; and

(b) must consult CPS when consideration is being given to charging a company with corporate manslaughter.

6 DECISION TO PROSECUTE

6.1 Any decision to prosecute following a work-related death should be co-ordinated and follow liaison between the police, the HSE, and CPS. There should be no undue delay in reaching the decision. Once a decision is reached the police should be advised.

6.2 Where the police do not propose to prefer charges, or the CPS decline to prosecute, the HSE should be advised of the decision as soon as possible in order that they may expedite proceedings for any related HSWA 1974 offence(s); subject to clause 8.2.

6.3 The prosecution decision should be made known to the accused and bereaved families prior to any public announcement through the arrangements agreed in clause 2.3.

6.4 The announcement of any decision to the media by the CPS and/or HSE should be co-ordinated.

6.5 Where a decision by the CPS is not to prosecute for manslaughter and clause 8.2 applies, the announcement shall make it clear that the decision by HSE will follow the inquest.

7 CPS PROSECUTION

7.1 Where the CPS prosecute, but HSE indicate that they wish to retain an interest, the CPS undertakes to keep HSE advised as to the progress of the case and notify HSE of the result of any court proceedings.

7.2 Where the allegation concerns a work-related death, the HSE will disclose to the CPS a copy of any report or document(s) submitted to the coroner. The report may not be disclosed to any party without the consent of the HSE.

7.3 The police or CPS will advise the coroner when a charge of manslaughter is preferred. The coroner may thereafter adjourn the inquest until the conclusion of the criminal prosecution. The Director of Public Prosecutions (CPS) may also request that a coroner adjourn the inquest where there are proceedings before the magistrates’ court for offences that are related to a death (section 16 Coroners Act 1988).
8 HSE PROSECUTION

8.1 Where the HSE prosecutes exclusively, following the decision to prosecute (see clause 6.1) there will in general be no need to advise CPS of the progress of the case unless CPS has requested that they be so advised.

8.2 Where the police decide not to prefer charges or CPS has reviewed the papers and declined to prosecute for manslaughter:

(a) in order not to prejudice any post-inquest review of the decision to prosecute for manslaughter, the HSE will await the result of the coroner’s inquest before preferring charges under the HSWA 1974 unless delay would prejudice the HSE case; and

(b) where the verdict of the coroner’s court causes the CPS to review their initial decision not to prosecute, the HSE will seek to ensure that their case is not heard until a further review has been completed by CPS.

9 JOINT PROSECUTION

9.1 Where CPS and HSE seek to proceed for offences arising from the same incident, a conference should be convened to discuss the management of the case with a view to initiating joint proceedings. In particular, the following issues should be discussed and agreed:

(a) who will take lead responsibility for the proceedings;

(b) the wording and nature of the charges;

(c) arrangements for the retention and disclosure of material;

(d) the timing of proceedings;

(e) arrangements for keeping bereaved families and witnesses informed;

(f) the announcement of the decision;

(g) arrangements for maintaining contact during the life of the prosecution and agree a mechanism for consultation should an issue arise which results in the prosecution being withdrawn or no further evidence offered; and

(h) any other case management issue.

10 NATIONAL LIAISON

10.1 The police, CPS and HSE shall form a national liaison committee which should meet at least once a year to review the operation of the protocol and consider the need for changes in arrangements.

11 LOCAL LIAISON

11.1 The police, CPS and HSE shall nominate identified local liaison officers. These persons should meet on a regular basis to discuss implementation of this protocol at a local level and other issues of mutual interest and concern.

11.2 The liaison officers’ responsibilities will also include:

(a) ensuring that there is an identified and accountable local line of effective communication between the three organisations;

(b) monitoring the effectiveness of the protocol; and

(c) communicating any issues that may have implications for the protocol or issues of concern to the national liaison committee.
Annex A (Clause 1.1(b))

A GENERAL GUIDE TO THE ENFORCEMENT OF THE HEALTH AND SAFETY AT WORK ETC ACT (HSWA) 1974 AND RELATED LEGISLATION

Health and Safety Executive

Enforcement of the HSWA 1974 and related legislation is shared with local authorities who cover certain types of work activities. As a general guide, the Health and Safety Executive (HSE) is normally the enforcing authority for work activities and premises including:

- Factories and other manufacturing, including motor vehicle repair
- Chemical plants and refineries
- Construction
- Railways, tram and underground systems
- Mines, quarries and landfill sites
- Farms, agriculture and forestry
- Hospitals, including nursing homes
- Local government, including their offices and facilities run by them
- Schools, colleges and universities
- Domestic gas installation, maintenance or repair
- Utilities, including power generation, water, and waste
- Fairgrounds (travelling or fixed)
- Airports (except terminal buildings, car parks and office buildings from April 1998)
- Police and fire authorities; Crown, including Ministry of Defence
- Docks
- Nuclear installations
- Offshore gas and oil installations and associated activities including pipe-lay barges, and diving support vessels
- Onshore major hazards, including pipelines, gas transmission and distribution
- Transport of dangerous substances by road and rail
- Manufacture, transport, handling and security of explosives

CONTACTING HSE OUT-OF-HOURS

The HSE is not an emergency service. It has produced guidance for police and other emergency service control rooms describing how to contact HSE inspectors out-of-hours.

LOCAL AUTHORITIES

In England and Wales, district, borough or city councils enforce the HSWA 1974 in respect of certain non-domestic premises, including:

- Shops and retailing, including market stalls, coin-operated launderettes, and (from April 1998) mobile vendors
- Most offices
- Some wholesale and retail warehouses
- Hotels and catering, including guest houses, hostels, caravan and camping sites, restaurants, pubs, cafés, and wine bars
Leisure and entertainment, including nightclubs, social clubs, circuses, sports facilities, health clubs, gyms, riding schools, racecourses, pleasure boat hire, motor racing circuits, and (from April 1998) museums, theatres and art galleries

- Places of worship and undertakers

- Animal care, including zoos, livery stables and kennels

Therapeutic and beauty services, including massage, saunas, solariums, tattooing, skin and body piercing, and hairdressing

Arrangements for liaison in circumstances where local authorities are the enforcing authority will be developed. In the meantime, existing local liaison arrangements should continue.
References

More information can be found in these free publications:

- HSE Advice and Information for Bereaved Families BF1 HSE Books 1995 (currently being revised)
- HSE Advice and Information for Bereaved Families (Scotland) MISC031 HSE Books 1995 (currently being revised)

HSE priced and free publications are available by mail order from HSE Books, PO Box 1999, Sudbury, Suffolk CO10 6FS. Tel: 01787 881165 Fax: 01787 313995.

HSE priced publications are also available from good booksellers.

For other enquiries ring HSE's InfoLine Tel: 0541 545500, or write to HSE's Information Centre, Broad Lane, Sheffield S3 7HQ.

CPS publications are available from Publicity Branch, 50 Ludgate Hill, London, EC4M 7EX, CPS web site: http://www.cps.gov.uk


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