



Corporate Manslaughter: the Government's Draft Bill for Reform

IOSH response to the
Home Office consultation on its
Draft Corporate Manslaughter Bill

Consultative
document

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Introduction

Established in 1945, IOSH has around 28,000 members, is Europe's largest occupational safety and health (OSH) professional body and has strong OSH links worldwide. Principally a UK-based organisation, it also has an expanding international membership, with members in over 50 other countries and Branches in Hong Kong and the Republic of Ireland. Incorporated by Royal Charter and a registered charity, IOSH is the guardian of OSH standards of competence in the UK and provider of professional development and awareness training courses. The Institution regulates and steers the profession, maintaining standards and providing impartial, authoritative guidance on OSH issues. Advancing research and disseminating knowledge is key to the IOSH mission of promoting work-related safety, health and sustainability.

IOSH members work at a variety of strategic and operational levels across all employment sectors. The Institution recognises the benefits to society, organisations and individuals of policy and practice that is underpinned by scientific evidence and our mission is:

“A world of work that is safe, healthy and sustainable”

The Institution has long lobbied for a new offence of Corporate Manslaughter as a necessary additional lever to improved corporate accountability and health and safety standards and we welcome the opportunity to comment on this important, landmark statutory instrument: *The Corporate Manslaughter Bill*.

In summary, IOSH broadly welcomes the Draft Bill, its extension to certain Crown bodies and its power to impose remedial orders, however, we would like to see some amendments and wider application, including: less Crown immunity; application extended to non-incorporated bodies; a wider definition of relevant duty of care; the removal of 'profit' from the test for gross breach; and also consideration of the use of additional / alternative penalties.

In the response that follows, we outline our main reasons for supporting the Bill and then make detailed comments and recommendations concerning applicability; the 'test' for gross breach; prosecutions; penalties; and suggested additional legislative changes.

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Background

IOSH believes a new offence of 'Corporate Manslaughter' is a necessary additional lever to improved corporate accountability and health and safety standards and that it will help in the following areas:

- to address the current unsatisfactory situation in which only small firms are likely to be successfully prosecuted for causing death, due to the need to prove gross negligence by a 'directing mind': the so-called 'identification' principle;
- to signal society's disapproval of serious corporate failures that lead to death and to improve public confidence in the legal system;
- to give those affected by such deaths some sense of justice in seeing culpable organisations convicted of the serious offence of manslaughter;
- to provide stronger deterrence to the minority of organisations who would otherwise disregard their health and safety responsibilities, through increased likelihood of successful prosecution and associated reputational damage; and importantly
- to improve health and safety standards by raising awareness of the importance of effective management and positive culture and by making mandatory and timely remediation a part of sentencing.

However, IOSH believes that legal sanctions are only a small element in an overall failure prevention strategy, based on improving national competence in the management of occupational safety and health. We believe this strategy should include increased awareness, commitment, resourcing and worker involvement, so that positive health and safety cultures are developed, and also that this should all be supported by higher levels of enforcement.

Comments on the draft Corporate Manslaughter Bill

Applicability

We welcome the fact that there is to be no general Crown immunity for the new offence of Corporate Manslaughter. We also believe that, in addition to those organisations listed in the consultative document, this offence should also apply to prisons, police forces, armed forces training establishments and all government departments where national security is not an issue. We believe the offence should equally apply to non-incorporated bodies, such as partnerships, to the extent those organisations owe 'a relevant duty of care' to the deceased. Whilst we understand the principle that certain 'activities' may be performed under statute or prerogative and so the organisations concerned should not be held liable for the consequences of their diligent discharge, we also believe that it should be for the Director of Public Prosecutions to decide whether a death may have occurred other than as a result of such diligent discharge and should therefore come before the courts.

We note that the new offence does not apply to British companies that cause death abroad. We understand the difficulties of enforcing the legislation to operations in other countries. However, we believe those organisations responsible for deaths abroad caused by gross negligence in their operations should be prosecuted, where those activities are organised or managed by senior managers operating within England or Wales.

Test for ‘gross breach of duty of care’

We agree that failure to comply with any relevant health and safety legislation and guidance should be part of the ‘test’ and believe that the definition of relevant guidance should be extended to include authoritative guidance produced by trade or advisory bodies that have Health and Safety Executive endorsement or recognition.

In respect to the ‘test’ element 3(2)(b)(iii), we are opposed to the need to show an organisation sought to profit from its breach, in order to secure a conviction for Corporate Manslaughter, as we do not believe a ‘profit motive’ to be necessary for establishing culpability. Additionally, we feel that such a motive may be unreasonably difficult to prove, particularly in the case of non-commercial organisations. However, in situations where organisations are found to have sought to profit, we believe that this should form part of sentencing considerations.

We note the duty of care for this offence is to exist where an organisation is acting as an employer or occupier of land; when supplying goods or services; or when engaged in other commercial activities. However, we believe that section 3 of the Health and Safety at Work, etc. Act 1974 is relevant, in order to cover situations where a duty of care is owed to others who may be affected by an organisation’s activities. This could apply for example, in cases of negligence with respect to control of Legionella or other toxic emissions to atmosphere or the management of occupational road risk, that cause fatalities among the general public. We therefore recommend the definition be extended to cover the same situations that are covered by section 3, along the lines of “duty owed by an organisation in control of an activity to the extent of its control, to those affected by the activity”. It is unclear (in paragraph 22) where the duty lies in the case of public bodies / local authorities providing services via third parties e.g. as part of partnership arrangements, private finance initiatives or through contracts and clarification should be given as to whether it rests with the public body / authority or the supplier.

We note that among the examples of possible sources of health and safety ‘warnings’ which may have been ignored in the course of the offence (explanatory notes, paragraph 18, second bullet point), there is no mention of the competent health and safety assistance (internal and / or external) which every employer is obliged to have access to under the Management of Health and Safety at Work Regulations, regulation 7. In his report following the Piper Alpha Public Inquiry, Lord Cullen judged ‘the management were remiss’ because they paid little attention to an internal assessment by a young engineer of possible large-scale pressurised gas fires. (Cullen, 1990, paragraphs 14.21, 14.23) The availability of a range of competent internal advice is typically greater in larger organisations, at which this legislation is specifically directed and we believe ignoring competent advice (internal or external) should be highlighted as a compounding factor in the offence. Other sources of ‘warnings or alerts’ that may have been disregarded as part of the gross breach could include for example: lessons from previous accidents or near misses; audit and inspection reports; and employee complaints or concerns.

Prosecutions

We believe that for most cases it will be necessary to charge organisations with both Corporate Manslaughter charges and offences under the Health and Safety at Work, etc. Act, in order to ensure appropriate convictions of culpable organisations, should the more serious offence not succeed.

We also believe that the Health and Safety Executive, with its extensive expertise in occupational safety and health management and key role in investigating work-related deaths, will have an invaluable part in determining whether a Corporate Manslaughter case should be brought and where appropriate, in helping to prepare such cases, and so will need to be adequately resourced for this function.

Penalties

In addition to unlimited fines, we welcome court powers to require remedial actions, within a specified time, addressing failures that led to the death. We would recommend that courts take a broad view of this and in addition to other measures, also consider requiring the compulsory training or retraining of senior managers in the management of occupational safety and health and that the organisation obtains appropriate health and safety advice. We believe it is essential that remedial orders ensure both immediate and root causes are remedied and that health and safety system failures and deficiencies in health and safety culture are addressed. We strongly recommend that the Health and Safety Executive should advise on the content and timescales of remedial orders.

When sentencing, we suggest consideration could be given, in appropriate cases, to suspending an element of the fine, subject to satisfactory completion of the remedial measures, as an economic incentive to offenders to demonstrate their timely compliance. With regard to possible non-compliance with remedial orders, we note the proposal is to impose a fine. However, in view of the important preventative nature of such remedial orders, we feel an additional sanction may sometimes be appropriate, such as a prohibition notice i.e. a notice requiring cessation of operations until satisfactory remediation has been demonstrated.

In respect to the prosecution and conviction of public bodies, where fines are ultimately paid by the public, we suggest an additional or alternative penalty could be to ensure that the conviction affects their 'Comprehensive Performance Assessment' or leads to an Audit Commission Inquiry. We also suggest that consideration be given to the use of the Health and Safety Executive's 'naming and shaming' website (HSE Public Register of Convictions) and to the careful / limited use of 'adverse publicity orders', where appropriate, possibly requiring convicted organisations to report their performance in their annual reports. Additionally, we note in the recent HSE commissioned research report *An evidence-based evaluation of how best to secure compliance with health and safety law* (Wright *et al*, 2005), that reference is made to the possibility of exploring 'restorative justice' in respect to health and safety offenders. The restorative justice process allows victims / victims families to impress upon offenders the real impact of their actions and to receive an explanation. As reported on the Home Office 'restorative justice' webpages, research suggests that at least 75 per cent of victims who take part in this process are glad they did so. Though early evidence on the effects on re-offending seems encouraging, it is inconclusive and there needs to be more research into its efficacy with respect to particular offences (Home Office, 2005).

Additional legislative change

In addition to the new Corporate Manslaughter offence, we propose that deaths in armed forces training establishments and work-related road fatalities should both be reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 and be investigable by the Health and Safety Executive, in conjunction with the Police. We also believe that the Health and Safety Commission's guidance on directors' health and safety responsibilities should be revised and re-issued as an Approved Code of Practice. (HSC, 2002)

Additionally, we suggest that consideration be given to harmonisation of Corporate Manslaughter and equivalent offences in Scotland, Northern Ireland and England and Wales, as many organisations operate across these borders.

References:

Cullen J (1990), *The Public Enquiry into the Piper Alpha Disaster*, Department of Energy, Report Cm1310, London, Her Majesty's Stationery Office

HSC (2002), *Directors' Responsibilities for Health and Safety*, INDG343, Sudbury, HSE Books

HSE Public Register of Convictions <http://www.hse-databases.co.uk/prosecutions/default.asp>

Home Office (2005), *Restorative Justice*, <http://www.homeoffice.gov.uk/justice/victims/restorative/>

Wright M, Antonelli A, Norton Doyle J, Bendig M and Genna R (2005), *An evidence-based evaluation of how best to secure compliance with health and safety law*, RR 334, Sudbury, HSE Books