THE CORPORATE MANSLAUGHTER & CORPORATE HOMICIDE ACT 2007

QBE ISSUES FORUM NOVEMBER 2007

QBE

THE 'DON'T KILL' BILL!
THE CORPORATE MANSLAUGHTER & CORPORATE HOMICIDE ACT 2007

QBE believe that best practice organisations are those where senior individuals facilitate and engage in the robust management of health and safety. We pro-actively encourage our clients to set in place the necessary organisational structure, systems and strategies to meet their moral, legal and financial obligations.

The question of how to hold organisations to account after major disasters has been the subject of an ongoing debate for many years. The Zeebrugge ferry disaster, which led to the deaths of more than 150 passengers and nearly 40 crew, some 20 years ago, brought the issue firmly into the public spotlight with the public enquiry identifying "a disease of sloppiness" and negligence at every level of the company's hierarchy. Despite an inquest jury returning verdicts of unlawful killing, there were no convictions of individual or corporate manslaughter.

The present government has been planning for almost 10 years to introduce tough legislation to take organisations to task when serious failings in health and safety lead to the death of an individual. The result is the Corporate Manslaughter & Corporate Homicide Act 2007, which received Royal Assent on 20 July 2007 and will come into full force on the 6th of April 2008. This issues forum will explore the provisions and implications of the new Act, and look at the framework of measures senior management should already have in place to ensure the effective health, safety and welfare of their employees, keeping them from under the spotlight of prosecution.

WHAT OFFENCE WILL IT CREATE?

The Act creates a new statutory offence in England, Wales and Northern Ireland of "Corporate Manslaughter", and "Corporate Homicide" in Scotland. Corporate manslaughter is a term used in English Law to reflect an act of homicide committed by a company as opposed to an individual. In a case following the Zeebrugge ferry disaster, the court of appeal confirmed in principle that a company can commit manslaughter, albeit that all the individual defendants in that case were acquitted.

An organisation will be guilty of the offence of corporate manslaughter if the acts or omissions of senior management cause a person's death. The failing could be either a single or series of errors, which directly lead to a gross breach of the duty of care owed by the employer to the deceased.

WHAT IS THE CURRENT POSITION?

The current law of corporate manslaughter links an organisation's guilt to the gross negligence of an individual who is said to be the embodiment of the organisation. It has proved very difficult to prosecute large organisations. Since 1992, there have been 34 prosecutions for corporate manslaughter of which only 6 have resulted in conviction. Notably, the only successful prosecutions have involved small companies where the individual in question was intimately involved in the health and safety activities.

A company may also be found guilty of breaching the main provisions of the Health & Safety at Work Act etc 1974 (HSWA) if it has failed to take all reasonably practicable steps to ensure the health and safety of its employees and those affected by its business. This duty of care obviously extends to fatalities and can lead to unlimited fines. The HSWA contains provisions to find directors, officers and managers personally liable and potentially subject to imprisonment, where a health and safety offence has been committed by the company with their consent or connivance, or is attributable to their neglect.

WHY THE NEED FOR CHANGE?

With manslaughter charges and unlimited fines already a possibility under current health and safety legislation, this is a valid question. The answer may partly lie in the current social climate where individual responsibility is increasingly seen to be hidden behind the façade of large organisations, which themselves cannot be taken appropriately to task. Fines solely levied against organisations are not seen to be an appropriate punishment for a fatality, where the

individual is seen as an innocent party. This view has been heightened by the media after similar cases to Zeebrugge such as Piper Alpha, the Kings Cross fire and the Southall rail crash, where attempts to prosecute these corporations and their senior management under the law of gross negligence manslaughter came under significant difficulty and ultimately failed.

The difficulty with the existing law of corporate manslaughter is that it does not reflect the realities of the modern corporate environment. Before a company can be found guilty, an individual who is a "controlling mind" of the organisation must first be found personally guilty of the offence. It is this "identification principle" that has led to serious difficulties in prosecuting medium to large organisations with diffuse management/corporate structures, and where health and safety has traditionally been delegated to a lower tier of management and health & safety professionals rather than the controlling/directing mind. Under the present law, it is not possible to add up the negligence of several individuals to show the company as being grossly negligent. In reality it is always likely to be the combined acts or omissions of individuals and/or processes, none of which can individually be qualified as manslaughter, which lead to a fatality.

It is telling that in recent times the courts have awarded more significant fines for breaches of health and safety legislation. It may well be that these fines have been in response to the difficulties of bringing corporate manslaughter charges under the current legal framework i.e. a perceived need to over-compensate to satisfy public demand.

WHAT DOES THE NEW ACT ACTUALLY CHANGE?

For all the attention this piece of legislation has received, it actually brings with it no new legal obligations for employers. What it does do is allow for the accumulation of what might be a series of collective errors to demonstrate that the defendant was deficient in managing an effective health and safety management system. The main focus of the Act is to establish the grounds upon which an organisation, rather than an individual, can be found guilty of the offence of corporate manslaughter. Moving away from the need for an individual "controlling mind" to be identified, an organisation will be guilty of the offence if the way in which its activities are managed or organised by senior management amounts to a gross breach of the duty of care owed to a person, and that breach results in the person's death. The prospect of individual liability under the Act is specifically excluded.

The intention of the Act is not to let individual directors off the hook but rather seeks to encourage management to adopt an approach of collective senior management responsibility for issues of health and safety that permeates the organisation rather than being concentrated in a single department or individual. All company directors and senior managers will now be required to take an active interest in these matters and to ensure that health and safety is a prime consideration in their business if they wish to avoid seeing their actions, or omissions, result in a court appearance should a fatal accident arise from a "gross breach" of their duty of care in this regard.

DUTY OF CARE

The key elements of the existing framework for corporate manslaughter are retained with the new Act i.e. the organisation must have owed a duty of care to the deceased, there must have been a breach of that duty and the breach must be "gross". In cases where an employer is charged with the death of an employee, the existence of a relevant duty of care will nearly always be straightforward. However, some scenarios could potentially involve a number of organisations with overlapping duties e.g. construction projects. This could lead to cases with multiple defendants. It is also possible that safety consultants and related experts could be included among defendants if their advice or services are deemed deficient. Regulatory bodies such as the HSE are excluded (except for their own employees), and there are special provisions limiting the duty of care owed by the emergency services.

It should be noted that the duty of care is not just to employees but will also apply to third parties arising from operations, including as occupier of premises, construction and maintenance work, supply of goods and services, use of vehicles and plant, and all commercial activities. For example, in relation alleged fatalities caused by the supply of defective products, manufacturers and suppliers will be required to demonstrate systems in place for safety and quality checks on all supplied parts and ingredients as well as the finished product. Product recall procedures will be required where goods have been supplied that are potentially faulty.

GRAVITY THRESHOLD FOR BREACH OF DUTY

Breach of a duty of care is to be regarded as "gross" if the organisation's conduct falls "far below what can reasonably be expected of the organisation in the circumstances". Given the potential for wide interpretation of this standard, the Act provides further guidance in applying the "gravity threshold". Factors that a jury will be required to consider include:

- Whether the organisation failed to comply with any relevant health and safety legislation.
- If they did, how serious was the failure and how much of a risk of death did it pose?
- The extent of the organisation's compliance with relevant health and safety guidance.
- Whether the evidence shows that there were "…attitudes, policies, systems or accepted practices within the organisation that were likely to encourage any such failure or to have produced tolerance of it."

In addition to the guidelines here, employers would be well advised to consider the sentencing factors used in previous health and safety prosecutions. For example, in the case of R&F Howe & Son (Engineers) Ltd (1999) Mr Justice Scott Baker suggested that the more serious aggravating features of a prosecution would include: putting profit before safety; failing to heed previous warnings; deliberate or reckless breach of safety; and how far short of an appropriate standard the defendant fell.

PENALTIES

In addition to an unlimited fine, the Act introduces a power for the courts to impose a remedial order on a convicted organisation to force it to resolve any management failure that may have been a cause of death.

Arguably the most effective aspect of the act will be to reclassify conduct already an offence, under existing legislation, with the more stigmatising term of corporate manslaughter (corporate homicide in Scotland). If there was any doubt that a prosecution under the new law would not attract the desired attention, the Act allows for "publicity orders". This will allow the courts to force convicted organisations to publish details of their offence and penalties at their expense.

IMPACT

In a regulatory impact assessment of the Bill, the Home Office estimated that the new Act will result in the number of prosecutions for the offence of Corporate Manslaughter rising from the current one or two to around 10-13 additional prosecutions a year. This would represent prosecutions for 3-4% of work-related deaths. The cost of prosecuting and defending these actions will inevitably rise from current levels, given that the scope of the investigation required to identify the "management and organisation of activities" and the "attitudes, policies, systems or accepted practices within the organisation" seems likely to require a great deal of time and effort, not to mention disruption to the day to day working of the organisation in question, during the period of investigation. It is also arguable that it will be easier to find companies guilty of the offence when the conviction of a director, with direct responsibility for the breach of duty, is no longer a pre-requisite to the conviction of the company for the offence of manslaughter. Fines are likely to be set at a level at least equal to those currently levied on organisations found guilty of breaches of the HSWA that result in a fatality.

Perhaps of greater concern is the stigma likely to be attached to an organisation found guilty of the new offence, and the potential consequences for its reputation and brand image. A key threat arising from a prosecution will be the harm that it might have on the company's brand, particularly in today's climate where supplier chain integrity is of paramount importance. Indeed, one can hypothesise that marketing departments may, for the first time, take an interest in their organisations' approach to health and safety management!

IMPLICATIONS FOR SENIOR MANAGEMENT

The new legislation serves to highlight and re-enforce the importance of addressing health and safety issues at a high level. Directors and other "senior management" should take the opportunity to review the management of, and responsibilities for, health and safety in their own organisations and ensure they have appropriate and effective health and safety processes. The management system should identify the appropriate structure, staff responsibilities, competencies and culture combined with a pro-active auditing framework that demonstrates conformity and seeks continual improvement.

Senior managers will not be able to demonstrate that they have discharged their duties by simply delegating health and safety responsibilities to more junior managers and health and safety professionals. They are to be encouraged to display leadership and play active individual roles in health and safety strategies and demonstrate not only appropriate risk assessments, clearly documented safe working procedures, relevant training and competence but also that these processes were stringently applied across the organisation and regularly reviewed to ensure that they were at all times a good fit to changing circumstances. That is to say that they are "managing the activities" of the organisation as the Act implies should be the case. The evidence reviewed will demonstrate more than compliance with legislation but also effective implementation and improvement when the need arises.It may also prove necessary to periodically call upon the services of external health and safety, and risk management experts in order to benchmark and validate organisations' endeavors against best practice.

Particularly important will be to ensure that procedures, expected standards and practices are communicated and demonstrated to employees and other potentially affected persons in a clear and effective manner so as to help formulate the necessary "attitudes… and accepted practices" (a clear reference to safety culture) within an organisation.

The Act fails to fully define the sort of "health and safety guidance" to which an organisation might be expected to have consulted and acted upon in the context of an alleged breach but this will undoubtedly include material such as ACOPs, HSE Guidance and British Standards. There may also be no restrictions on a jury looking at wider industry guidance, research reports etc. The HSE website will provide a useful starting point, with its facility for searching by industry type or health and safety topic. Organisations under the spotlight will be hoping that the courts and juries take a pragmatic and realistic view on the issues of foreseeability and what is reasonably practicable in the unique and particular business circumstances they may face.

It is also important to remember that while the new law has no impact on individual liability, prosecutors will still be able to target directors and senior executives for gross negligence in the conduct of their management roles under Section 37 of the HSWA. Also, the new Act will be in addition to, and will not replace the existing Scottish offence of Culpable Homicide, and the existing Common Law manslaughter offence under which individuals and directors / owners of small businesses have previously been successfully prosecuted for manslaughter offences.

KEEPING UP TO DATE – CONTINUOUS IMPROVEMENT

The Act effectively requires of organisations that they make, and for their own sake record, every effort to keep abreast of developments in health and safety in their line of business. Organisations, on completion of their risk assessments, should review and introduce new engineering and other "higher order" hierarchical solutions through product or process to minimise the risk of identified hazards. Trend analysis of incidents should include corrective actions to reduce future occurrence or severity.

For the majority of organisations with registration to a recognised management system e.g. ISO 9001, ISO14001 or BS OHSAS 18001, the process of Plan, Do, Check and Act to improve will be recognised.

TIME TO TAKE ACTION?

The good news is that the explanatory notes to the Bill state: "There is no question of liability where the management of an activity includes reasonable safeguards and a death nonetheless occurs". With the provisions of the Act not due to come into force until April of next year, there is time yet for organisations to address any shortcomings in their governance structure, policies and systems. It must be recognised, however, that company-wide attitudes and accepted practices may take more time to change.

WHAT DOES SENIOR MANAGEMENT BEST PRACTICE LOOK LIKE?

While there has been much attention to the arrival of the new legislation, there has been, as yet, little commentary on how an organisation and its senior management can mitigate the prospects of a successful prosecution against them. Inevitably, there is some uncertainty as to how the various tests for establishing systemic management failures will apply in practice and this is likely to remain the case until precedents are set and pored over. However, there is well established guidance out there as to what directors and senior managers should be doing already.

GUIDANCE FOR DIRECTORS AND BOARD MEMBERS

"Revitalising Health & Safety" was the joint Government and HSE strategy, launched in 2001, to inject some impetus into the health and safety agenda. At that time they produced guidance, within the context of wider corporate governance, outlining directors' and board members' responsibilities for Health and Safety (INDG343). While guidance does not hold the same legal weight as statutory duties or Approved Codes of Practice, in the context of establishing grounds for a prosecution under the new Act, it will be highly relevant. In the guidance, five main principles were set out:-

1. The board must accept formally and publicly its collective role in providing health and safety leadership;
2. Each member of the board needs to accept their individual role in achieving this;
3. All board decisions must reflect the intentions expressed in their health and safety policy statement;
4. The board must recognise its role in engaging the active participation of workers in improving health and safety.
5. The board must be kept informed of all risk management issues, preferably by the appointment of a health and safety director.

At the time of writing, the HSC in conjunction with the Institute of Directors were due to publish updated guidance for directors on their health and safety responsibilities. This guidance (INDG417) entitled *Leading health and safety at work: leadership actions for directors and board members* is now available for free download from the corporate manslaughter pages of the the HSE website.

COMPLIANCE

Taking a basic compliance approach, the general duty of care owed by employers to employees and others affected by their business is outlined under the HSWA and further expanded on in the Management of Health and Safety at Work Regulations (MHSWR). Some of the basic framework requirements are as follows:-

- The HSWA requires that you need to prepare, and make sure your workers know about, a written statement of your health and safety policy and the arrangements in place to put it into effect.
- These general duties on employers are expanded and explained in the MHSWR, which include requirements for employers to assess the work-related risks faced by employees and by people not in their employment;
- To have effective arrangements in place for planning, organising, controlling, monitoring and reviewing preventive and protective measures;
- To appoint one or more competent persons to help in undertaking the measures needed to comply with health and safety law and;
- To provide employees with comprehensible and relevant information on the risks they face and the preventive and protective measures that control those risks.

MANAGEMENT SYSTEMS

With the Act focussing on systemic failures to manage health and safety in organisations, it follows that the multitude of work-related hazards requires a systematic approach to health and safety management. In recent years, one of the predominant management tools has been formal occupational health and safety management systems. The reference under the MHSWR to having effective arrangements for planning, organising, controlling, monitoring and reviewing preventative and protective measures (or Plan, Do, Check, Act) provides similarity of many familiar management systems approaches to health and safety, such as HSG65 and BS OHSAS 18001, which strive for continual improvement as their overarching intent. The organisations that use a management system as a framework for being pro-active will be able to demonstrate their integrity as opposed to those organisations who use a certificate of accreditation as lip service.

Organisations should be mindful of hiding behind a veil of compliance or third party certification to management systems as all they need to do. The new legislation will be able to permeate and interrogate organisations that pay lip service to such matters, demanding evidence of a pro-active and holistic inter-departmental management (i.e. non-silo) approach to health and safety that is embedded in the wider culture of the organisation and led from the most senior management positions.

CONCLUSIONS

Organisations who fail to recognise this Act as a significant and subtle piece of legislation will do so at their peril. It removes many of the barriers to a successful prosecution under the existing legal framework and without question, stigma and reputation / brand damage will be the Act's biggest weapon. Demonstration of effective management systems and a risk aware safety culture are likely to be key battlegrounds at trial. The acts and omissions of senior individuals will be under the microscope as never before.

FURTHER INFORMATION

More information can be found on the HSE website: www.hse.gov.uk and the full contents of the Act can be viewed at http://www.opsi.gov.uk/acts/acts2007/20070019.htm

AUTHOR BIOGRAPHIES

Mark Black, Liability Risk Manager
Mark joined QBE in 1998 serving 6 years as a liability claims inspector before joining the Liability Risk Management team in 2004. He holds an honours degree in Risk Management and the Nebosh National Diploma in Occupational Safety and Health.

Jonathan Coatman, Claims Controller
Jonathan is a liability specialist within the QBE Strategic Claims team based in London. His role primarily involves the management of claims with significant financial value in the areas of employers' liability, public liability and professional indemnity. Jonathan also provides technical input to the risk management, underwriting and actuarial functions within QBE and on behalf of external clients through briefing notes, articles and consultancy.

QBE
Plantation Place,
30 Fenchurch Street,
London,
EC3M 3BD
t: + 44 (0)20 7105 4000
f: + 44 (0)20 7105 4019
enquiries@qbe-europe.com
www.QBEeurope.com