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Corporate manslaughter

The offence of manslaughter is part of the "common law", the traditional, unwritten law of England and Wales which has existed since time immemorial.

Over the centuries, the legal system has developed the concept of "manslaughter by gross negligence", by which an individual person is guilty of an offence if:

- he owes a “duty of care” to the deceased
- he breaches that duty of care by a negligent act or omission
- the breach of the duty causes the deceased’s death
- the breach is so serious as to be characterised as “gross negligence” and, in consequence, a crime.

More recently, the police and the Crown Prosecution Service have attempted to use this offence to prosecute organisations. The attempt was unsuccessful, as can be seen from a series of high profile failed prosecutions such as the Herald of Free Enterprise case onwards, but the failures fuelled a widespread social demand for the law to be changed to enable such cases to be easier to prove against defendant organisations. The Corporate Manslaughter and Corporate Homicide Act, which comes into force on 6 April 2008, is the response to that demand.

It is important to remember that, despite this Act, the offence of manslaughter by gross negligence continues to apply to any individual, including a manager, who is involved in the death of any person, including the death of an employee. All that the Act has changed is the way in which an offence of manslaughter by gross negligence is proved against an organisation.

The new offence

Most deaths at work are caused by systemic failings, rather than by the default of one person. For this reason, the focus of the Act is not on the immediate cause of the death (ie the actual act or omission that led to the death), but on the root cause (ie the failure in the system which allowed the act or omission to occur).

Systemic failings are evidenced by a series of small acts or omissions that, taken in isolation, cannot be said to have caused the death, but, taken together, can be said to have caused the death.

In the Herald of Free Enterprise case, for example, when a cross channel car ferry capsized and sank as it left Zeebrugge harbour because its bow doors were left open:

- the man whose job it was to shut the bow doors was asleep in his cabin
- the man who could have shut the doors instead said it wasn’t his job and left them open
- there was no warning light on the bridge to warn that the doors were not closed
- there was no CCTV on the bridge so that the duty officer could see what was happening
- the duty officer interpreted company standing orders to mean that he could leave the berth once orders had been given to close the doors, not once the doors had been closed

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- the chief officer took over responsibility for loading from the second officer, shortly before departure, without ascertaining what other duties he was assuming
- there was management pressure to leave the berth early
- the captain failed to check with his officers that the ship was ready for sea
- the company standing orders were mutually contradictory.

The Command Paper which introduced the Bill said that the Act is designed to catch "truly corporate failings in the management of risk, rather than purely local ones."

In attempting to achieve this systemic focus, however, the draughtsman of the Act has created a tortuous definition. In order to understand the scope of the new offence, therefore, it is necessary to paraphrase it as follows:

> "If the way in which an organisation's activities are managed or organised by its senior management:
>
> – causes a person's death; and
>
> – amounts to a gross breach of a duty of care owed by the organisation to the deceased; and
>
> – is a substantial element in the breach
>
> the organisation is guilty of corporate manslaughter."

Every criminal offence can be divided into "elements". The elements of this offence are:

- the organisation owes a duty of care to the victim
- the breach of that duty of care is a gross breach
- the breach of the duty of care is substantially due to the way in which the organisation's activities are managed or organised by its senior management

This article will examine each of these elements in turn.

What is a 'duty of care'?

The requirement of a duty of care is, in effect, a precondition: if there is no duty of care then there is no liability.

Not every duty of care matters for the purpose of the Act. Instead, the Act says that what matters are 'relevant' duties of care, which it defines as any duty owed under 'the law of negligence' in relation to certain listed activities.

This definition can make it difficult for organisations to decide how to accommodate the Act: it defines liability by reference to duties under 'the law of negligence', not to duties under the Health and Safety at Work Act (HSWA) and associated regulations, whereas most organisations manage risk by reference to HSWA, not the law of negligence. The function of the law of negligence is to decide on issues of compensation, not to set workplace standards.

Duties owed under the HSWA, therefore, may not be owed under the law of negligence and vice versa. So to say, for example, that if an organisation complies with health and safety law it cannot be guilty of corporate manslaughter is to over-simplify the position. It is a good rule of thumb and a good starting point, but it may not be entirely accurate.

The effect of this definition is to introduce a two stage test in order to decide whether a relevant duty of care is owed:

1. Is a duty of care owed in this situation under the general law of negligence? If it is,

2. Does the situation fall within one of the listed categories?

The 'law of negligence' in this context is defined to mean:

- the law which says that if a person negligently causes injury to someone to whom he owes a duty of care, he has to pay compensation
- the law which says that if someone breaches a regulation and causes injury to someone, he has to pay him compensation (eg the Control of Noise at Work Regulations)
- the law which says that if someone breaches the Occupiers Liability Acts or the Defective Premises Act and causes injury to someone, he has to pay him compensation.

So a good rule of thumb to answer the first question is that the potential range of victims who should be in the contemplation of an organisation are those to whom it thinks it would be liable to pay compensation if its activities caused them injury.

In relation to the second question, the list of categories comprises all duties owed:

1. to employees and others working for the organisation or performing services for it
2. as an occupier of premises
3. in connection with the supply of goods and services
4. in connection with the carrying on of construction or maintenance operations
5. in connection with the carrying on of any other commercial activity
6. in connection with the keeping of plant, vehicles or other things

These categories are not industry sectors, but classes of factual situation. So any given business could fall within more than one situation, depending upon what different activities it is engaged in at any one time. For example, a manufacturer owes a duty:

- under (1) to its employees and sub-contractors at the workplace
- under (2) to visitors to its factory
- under (3) to people who purchase its products
- under (4) to members of the public walking under scaffolding being used in connection with the construction of an extension to the factory
- under (5) to members of the public who might be affected by its products while in transit with an independent courier
- under (6) to members of the public who might be affected by the dangerous driving of one of its employees

Most of these are self explanatory, but two are worthy of closer analysis.

Construction or maintenance operations

These are defined as covering:

- construction, installation, alteration, extension, improvement, repair, maintenance, decoration, cleaning, demolition or dismantling of:
  - any building or structure
  - anything else that forms, or is to form, part of the land, or
  - any plant, vehicle or other thing
- Operations that form an integral part of, or are preparatory to, or are for rendering complete, any of the operations listed above

The carrying on of any other commercial activity

This is intended to cover activities such as:

- agriculture

- fishing
- mining
- public utility infrastructure businesses (eg pipelines)

Is it possible to owe a duty of care through independent contractors?

The general rule under the law of negligence is that an organisation does not owe a duty of care in respect of the acts of one of its sub-contractors, provided that the organisation has used reasonable care in the selection of the sub-contractor and has not itself by its own actions caused the injury through the sub-contractor, for example by directing the sub-contractor to do an act which will foreseeably cause injury.

This general rule, however, is qualified by a number of complicated and vague exceptions, to such an extent that it would not be sensible to plan on the basis that there is no duty of care, nor would it be possible to construct a rational plan which took into account all the exceptions.

A prudent approach, therefore, would be for an organisation to assume that if it uses a sub-contractor, it is liable for the sub-contractor's negligent acts which affect others (including negligent acts which injure the subcontractor's own employees) and should plan for this in the same way as it would plan for liability under section 3 of HSWA.

What is a 'gross breach'?

A breach is 'gross' if the conduct involved "falls far below what can reasonably be expected of the organisation in the circumstances".

Factors a jury must consider

In making a decision as to whether a breach of duty is gross, a jury is obliged to consider whether the evidence shows that the organisation failed to comply with any health and safety legislation that relates to the alleged breach, and if so:

- how serious that failure was; and
- how much of a risk of death it posed

"Health and safety legislation" is defined in the Act as meaning HSWA and any other statutory provision dealing with health and safety matters.

The effect of this is to introduce two areas of complexity.

The first is that whilst the precondition for liability (the existence of a duty of care) is defined by reference to the law of negligence, the standard by which any organisation which is judged to have breached the duty of care is health and safety legislation. Yet there are disparities between the law of negligence and health and safety legislation. For example, there is a string of recently decided cases on occupiers' liability which says that if the injury is caused not by the state of the premises, but instead by the way in which the premises are used (or misused) by the visitor, (eg children climbing on a fire escape, partygoers trespassing on a roof and dancing on a skylight) the occupier owes no duty. The Health and Safety at Work Act, however, is interpreted by the HSE in relation to occupiers of premises to cover all risks, not just risks arising from the state of the premises.

The second is that the definition of "health and safety legislation" is not precise. By way of an example, there is a recent decision of the Court of Appeal that the Supply of Machinery (Safety) Regulations are not health and safety regulations within the meaning of HSWA, but it is arguable that under this Act they would be regarded as health and safety legislation

Factors a jury may consider

In making a decision as to whether a breach of duty is gross the jury is allowed to consider:

- the extent to which the evidence shows that there were attitudes, policies, systems or accepted practices within the organisation that were likely to have encouraged the failure to comply with legislation, or to have produced tolerance of it

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- any health and safety guidance that relates to the alleged breach
- any other matters they consider relevant

The intention of the first point is to encourage organisations to focus on their systems and on their safety culture.

The intention of the second point is to encourage organisations to use official guidance to set standards. “Health and safety guidance” is defined by the Act to mean any code, guidance, manual or similar publication that is concerned with health and safety matters. This definition may have the following unintended side effects:

- the only types of guidance which currently have the status of quasi legislation are "Approved Codes of Practice" (ACoPs). This new provision effectively elevates to that status all other guidance (eg the HSE's INDG series) of which there is a considerable volume.
- The new status is given to any guidance issued by any authority responsible for the enforcement of any health and safety legislation. Any Environmental Health Department of a local authority, for example, can issue guidance which will now have the status of law in corporate manslaughter proceedings, whether or not it is the organisation's enforcing authority under HSWA. Given that the HSE and local authorities do not always see eye to eye over the enforcement of health and safety legislation there is a potential for confusion.

Who are "senior management"?

The issue of who is or is not senior management determines the actions which will be focussed on for the purpose of determining the organisation’s liability. It does not, however, determine who could personally be prosecuted for individual manslaughter. Liability for individual manslaughter remains the same as before the Act. Managers should, therefore, keep a sense of proportion when thinking about this issue and should not over-delegate in the misguided assumption that this will prevent them from being regarded as senior management and in consequence immune from prosecution.

The Act defines senior management as being the people in an organisation who play significant roles in:

- the making of decisions about how the whole or a substantial part of its activities are to be managed or organised
- the actual managing or organising of the whole or a substantial part of those activities.

The Command Paper says that:

- the new offence is targeted at failings in the strategic management of an organisation’s activities, rather than failings at relatively junior levels
- organisations are not liable on the basis of any immediate, operational negligence causing death, or indeed for the unpredictable, maverick acts of its employees

The definition in the Act appears to support this: the people who are encompassed by it are those who have a senior management role generally, not those who have a senior role in health and safety.

Senior management, therefore will be:

- main board members
- divisional board members
- (in a large organisation) executives immediately below board level; for example at divisional or regional level

The smaller or more specialised the organisation, the more 'significant' the roles become lower down the management chain. Such organisations may have managers whom they would not normally regard as senior, but who would be regarded as senior under this Act: eg

- the site manager in a small construction company
- the CPC holder in a business which has a large transport operation

The following are unlikely to count as senior management, as they do not play a 'significant role' in the

making of decisions about how 'the whole or a substantial part' of the organisation is managed:

- the risk and compliance manager
- the health and safety manager

Their performance may, however, be relevant, because if the way in which senior management organises or manages the business is found to be deficient, a jury will also consider the systemic and cultural aspects of the organisation in deciding whether the breach is gross; if the risk and compliance manager is deficient, it may suggest that the whole system is inadequate.

What does "the way in which an organisation's activities are managed or organised" mean in practice?

For the organisation to be convicted, the way in which the organisation's activities are managed or organised need not be the sole factor in the breach, but it has to be a 'substantial element' in it.

The way in which an organisation's activities are managed or organised includes the way in which they are not managed or organised.

In other words, an organisation cannot escape liability simply by delegating responsibility for health and safety to junior management, or by ignoring it altogether.

The purpose of this element of the Act is to encourage strategic direction to start from the top, as a total delegation of responsibility would be tantamount to a total abdication of responsibility.

Does the new Act require organisations to make changes to the way in which they manage or organise health and safety?

The answer to this question is that it depends upon how the organisation manages or organises health and safety at the moment.

There are two essential guides to the organisation of health and safety:

- "Leading Health and Safety at Work" (INDG417), available on line from the HSE: http://www.hse.gov.uk/pubns/indg417.pdf
- "Successful Health and Safety Management" (HSG65), published by the HSE Books

"Leading Health and Safety at Work" is a joint publication by the HSC and the IoD. Its 12 pages describe how organisations of all types can lead and promote good practice in health and safety, structured around the core principles of planning, delivery, monitoring and review. It contains a useful checklist of areas where an organisation might benchmark itself. It also contains the specific warning that it is 'guidance' within the meaning of the Act and that, in consequence, in any prosecution under the Act, its advice could be a benchmark against which the defendant organisation's management systems might be judged.

"Successful Health and Safety Management" is a more detailed document which suggests a circular approach to health and safety structured around the core activities of policy, organisation, planning and implementing, measuring performance, reviewing performance and audit and so feeding back into policy.

The concepts in each publication are equivalent to one another:

HSG65	INDG417
Policy, Organisation and Planning	Planning
Implementing	Delivery
Measuring Performance	Monitoring
Reviewing Performance	Review
Audit	Monitoring and Review

The basic messages of both publications are:

- good health and safety starts at the top; without good leadership and direction from the board on health and safety it is unlikely that the health and safety culture of the organisation will be adequate
- risk management is the key process for any system

The answer to the question posed at the beginning of this section, therefore, is that, by way of initial response to the Act, a board should:

- take control of health and safety and ensure that it is a regular board issue. There is no risk to the organisation in this: as this article has demonstrated, talking about health and safety at board level does not make an organisation more likely to be prosecuted under the Act; on the contrary, it is a failure to do so that will make a prosecution more likely
- check that its health and safety system incorporates the core activities of INDG417 or HSG65
- check that the system is a properly resourced and living system. Too often boards will sanction the spending of large sums of money on setting up an HSG65 compliant system on paper, only to find a few years later after an accident that the system's recommendations have not been implemented due to lack of resource or that the glossy manuals lie unopened and unused

Once the board has satisfied itself on these points, the rest will follow, because the systems described above are designed to ensure that the board retains an overview of health and safety. The board will, however, need to become actively engaged when there is some significant change in the organisation, such as the introduction of a new process, a change in key personnel or an acquisition of another business.

In setting standards, the board should, first, focus on the requirements HSWA and of regulations made under it as a minimum, because, in general terms, these are wider than the law of negligence and will, in any event, need to be complied with in order to avoid prosecution under general health and safety law. In understanding those requirements, the board should have regard to official guidance issued by its regulatory body. Any 'competent person' appointed to assist the organisation to meet its obligations under health and safety law should be aware of such guidance.

Secondly, the board should review the range of people to whom it believes that compensation might be payable in the event that the organisation's acts or omissions cause them injury. If this review identifies a range which is wider than that required by HSWA, the health and safety system should be amended to encompass the wider range.

Does the Act apply outside the UK?

The Act applies in any case where the harm resulting in death is sustained in the UK, within UK territorial waters, on a UK registered ship, on a British controlled aircraft or hovercraft or on an oil rig or similar off-shore structure to which UK criminal law applies.

It does not apply to British companies responsible for deaths abroad, unless the harm resulting in death was sustained in the UK.

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