

**INTERNATIONAL SOCIETY FOR THE REFORM
OF CRIMINAL LAW**

**20th Anniversary Conference
Twenty Years of Criminal Justice Reform: Past Achievement
And Future Challenges**

June 22-26 2007, Vancouver BC, Canada

***THE NEW CORPORATE KILLING PROPOSALS
AND GENERAL CLIMATE***

WHERE ARE WE NOW AND WHERE ARE WE GOING?

GERARD FORLIN

LL.M (LSE), M.Phil (Cambridge),
Diploma in Air and Space Law
2-3 Gray's Inn Square
London WC1R 5JH
Tel: 020 7421 1848/ 020 7242 4986
Mobile: 07947 136349
Fax: 020 7405 1166
e-mail: Gerard@gerardforlin.com
www.gerardforlin.com
June 2007

INTRODUCTION

In the blame culture of today, there is an ever-increasing public call for accountability that companies and institutions can no longer ignore; especially in wake of the ENRON, Parmalat and World.Co scandals. See the latest scathing details on the attitude of safety by BP in the United States

Safety cases and risk assessments are just one method by which undertakings can show that they have done all that is reasonably practicable (and hopefully prevent death and injury as well!) They do not, however, provide a defence on their own and the benefits of the information contained in the documentation must be widely disseminated and be easily accessible to all employees. This needs to be provable to the prosecution!

Gold plated safety cases costing thousands of pounds sitting in an operation's director's room gathering dust will not do any good to both the company and their employees, and will be of very little use in any defence of a subsequent alleged breach of safety.

In the financial world a tougher line is being taken. This for example can be seen in the following:

- The Enterprise Act 2002
- Sarbanes-Oxley Act in the US that introduced fines of up to \$5 million and prison sentences of 25 years for Chief Executive Officers and others who signed misleading accounts.

This is being replicated too in relation to health and safety issues, particularly where death occurs as a result of management failures. This case considers the existing law and looks at the Government's proposals for corporate killing.

1. CORPORATE MANSLAUGHTER BY GROSS NEGLIGENCE (HISTORICAL PERSPECTIVE)

With the General Election then looming, and in response to ongoing pressure from certain back benchers and unions, following the Queen's Speech in November 2005, the long awaited draft Corporate Manslaughter Bill was published. Instead of Mr Blunkett, we found a forward by Charles Clarke. Alongside this was a consultation document with a closing date of 17 June 2005.

The key proposals included:

1. A new offence of Corporate Manslaughter if the way in which any of the organisation's activities are managed or organised by senior managers:
 - (a) Causes a person's death and
 - (b) Amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.
2. Includes Crown bodies (with certain exemptions).
3. Allows the court to order breaches to be remedied.

4. Provides for unlimited fines.
5. Does not target individuals themselves but instead prosecutes on the basis of the liability of the organisations themselves. Individuals still to remain liable to prosecution in their own right.
6. Parent companies will be included.
7. Unincorporated bodies probably exempt.
8. The offence would apply in England and Wales and would not carry extra territorial jurisdiction.
9. Private prosecutions would require the consent of the DPP.
10. Special consultation process – with a closing date of 17 June 2005.
11. Scotland and Northern Ireland to have a separate consultation exercise.

On 20 December 2005 The Home Affairs and Work and Pensions Committees of the House of Commons published a three volume report of their analysis of the Government's Draft Manslaughter Bill which had first come into being in March 2005. They had both oral and written evidence from a plethora of witnesses belonging to a variety of interest groups and came to a number of conclusions which in some instances differed wildly from that of the Government.

In November 2005, completely separate to this report, the Scottish Expert Group reported on their views of culpable homicide. At first blush there appeared to be a degree of symmetry between the Select Committee and the Scottish Group. It is further interesting to note that from the Scottish perspective they were able and willing to plough their own furrow stating that uniformity with England is not a priority "..... what is important is to get the law right for Scotland".

On the other hand the Select Committee stated in relation to Scotland that they should be as cohesive as possible "..... the Government should be doing all it can to ensure there is little practical variation as possible".

Space forbids a detailed analysis of the Select Committee's report but they concluded that the amendments, as below, should be made to the Draft Bill. On 5 February 2007, the Lords voted by a 96 majority not to allow the Bill to go through without amendment. They wanted the exclusion of death in prisons and police cells to be removed. The Attorney General is currently reviewing this. The Home Office said then "We have made it clear that we do not consider that this is appropriate and will seek to reverse this when the Bill returns to the Commons – where there was a substantial majority in favour of exclusion." The Bill is ping ponging between the Houses trying to beat the July 21st 2007 deadline. The reality is that this will probably postpone the introduction of the Bill until October 2007 rather than July 2007 - no one knows for sure.

1. The current proposals to have a test of gross breach by a senior manager be cut away and replaced by a test of gross management failure, which could be partly measured against a benchmark of whether there has been any failure to comply with health and safety regulations which, they opine, should be an important factor for the jury in assessing whether there has been a general gross management failure.
2. Parent companies should be culpable for the gross management failure of their subsidiaries. The Committee wants this further extended to employment agencies and principal contractors.

3. They want jurisdiction extended so that deaths anywhere in the UK trigger the offence. Further, they see no issue with jurisdiction being extended to within the EU, and also outside that geographical scope, for organisations to have to provide information to the UK authorities about the death. The Scottish panel think the offence should apply equally to deaths in Scotland caused by organisations based outside Scotland and to deaths caused outside Scotland by organisations based within Scotland. It is unlikely in the short term that the Government will budge but the Committee's wish list does mirror an ever increasing trend of expansion of extra-territorial criminal and civil jurisdiction, e.g. in personal injury and terrorism cases, and, within Europe, the advent of Euro warrants is likely to make this even more so.
4. The Committee want a further pruning back of Crown Immunity leaving only that central and high level public policy issues such as at NHS procurement level. This is bound to agitate the Civil Service and impact on general morale.
5. The Committee in a total volte face to the Government position, urges new legislation so that anyone who has a secondary role in the gross management failure can be prosecuted and sentenced up to 14 years imprisonment. This proposal is bound to slow down the Bill and I do not see it getting onto the statute books. Further, they want a separate directors' statutory code of health and safety and a raft of new sentencing procedures, including corporate death sentences and equity fines. Also proposals for directors to be held in contempt if the organisation fails to effect the court's imposed changes to a system. It is perhaps interesting that the Scottish Advisory Panel advocate that the offence of corporate manslaughter be extended to serious injury and occupational illness.

The Offence of Corporate Manslaughter

The offence is set out in Clause 1(1):

*“An organisation [corporation or other relevant body] ...is guilty of an offence [of corporate manslaughter] if the way in which its **activities are managed or organised-***

- (a) **causes** a person's death, and*
- (b) amounts to a **gross breach** of a **relevant duty of care** owed by the organisation to the deceased.”*

Clause 1(3) states:

*“An organisation is guilty of an offence under this section **only if** the way in which its activities are managed or organised by its **senior management** is a substantial element of the breach referred to in subsection (1).*

Causation

The relevant 'management failure' need not be the sole cause of death; it need only be a cause. Compare this with the manslaughter offence under the current law that requires the failure to be a *substantial* cause of death. The courts might imply a "substantiality" requirement into the new offence, but if they do not then the bar to conviction seems to be lowered as respects causation.

Relevant Duty of Care

The organisation must owe to the deceased a duty of care connected with the organisation's activities. The relevant duties are set out in Clause 2. It is for the trial judge (not the jury) to determine whether such a duty exists.

Senior Manager

The failure must be at 'senior manager' level. A 'senior manager' is defined in Clause 1(4) (c). The definition identifies those whose management *responsibilities* relate to *the whole* of an organisation's activities or to a *substantial part* of them. It is intended that management conduct be considered collectively as well as individually (thus failures of different managers can be aggregated, which under the current common law test they cannot be). The definition is intended to identify two strands of management responsibility – the taking of decisions about how activities are to be managed or organised: and actually managing those activities.

Gross Breach

This is set out in Clause 1(4)(b):

“ a breach of duty of care by an organisation is a “gross” breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances”.

Factors for the jury to consider are set out in Clause 8. The jury must consider whether the organisation failed to comply with health and safety legislation and if so (a) how **serious** that failure was, and (b) how much of a **risk** it posed. The jury may consider health and safety guidance and the organisation's 'safety culture'. The jury is not precluded from considering any evidence it thinks relevant to the issue. This clause may also impact upon the way the issue of 'gross' is considered in respect of an individual prosecuted for manslaughter alongside an organisation.

The law will also include organisations providing goods and services to members of the public, the construction, use or maintenance of infrastructure on vehicles, or when operating commercially.

The new offence also removes the remaining vestiges of Crown Immunity and other public sector organisations such as police forces and “puts them on an equal footing with the private sector when carrying out similar activities.”

To the dismay of many it will not include the wider issues of strategic government functions like the spending of public money or activities such as statutory inspections.

It is further almost inevitable, therefore, that fines for convictions of major corporations for corporate manslaughter will result in fines in excess of £20m-£50m upwards in the near future.

There is still a long way for the Bill to go as various pressure groups lobby for changes to the Bill - see below.

Further analysis of these factors will be given in the lecture.

See also: (1)Archbold News, 2 November 2006, *Sentencing Corporations* (2) New Law Journal, 24 November 2006, *Corporate punishment*".

There have been public inquiries which have yet again heavily criticised corporate failures that have resulted in deaths. Aviation, as many other industries, is heavily interconnected with others. So is Road Haulage - see the Road Traffic Act 2006 [November].

On the 19 June 2001 Lord Cullen delivered his report into the Paddington train crash. It is a ground breaking report for safety in all industries.

1. HSG 48 and 65 accepted.
2. A clear need to identify the underlying causes of incidents and not just blame front line workers.
3. The recommendations from incident investigations need to be followed through and risk assessed as appropriate.
4. Cullen's analysis shows that human error is in the vast majority of cases a consequence, not a cause of incidents.
5. The importance of human factors has been front-lined rather than just bolted on as an afterthought.
6. Human error is a hazard that should be risk assessed.
7. If track or signalling is altered, it needs to be risk assessed.
8. It is the readability of a signal not just its visibility that is crucial.
9. SPADS should not just be seen as a driver issue, for example review of signaller's actions once a SPAD has occurred must be considered as well.
10. There should be a review of signal sighting standards to take into account things like the time the driver has to see signals and the height of a driver's position in a cab, etc.
11. The importance of clear and unambiguous instructions for emergency situations such as the instructions to signallers in SPAD scenarios.

On page 136 of the report Cullen says

"The lessons from this disjointed and ineffective activity in SPAD management is clear, and do not need to be the subject of a recommendation. It is for management to ensure that safety responsibilities and accountabilities are well understood."

On page 137 he says

"... There was an inability to consider the problems of the Paddington area and the potential solutions as a whole. There was a reluctance to carry out risk assessments, and a deep seated laissez-faire culture within the zone. There was a reluctance to consider solutions which might impact on capacity and performance and there were a number of management deficiencies, of which I have given examples .."

On page 119

"... No attempt was made to carry out the required risk assessment by whatever methods were available".

On page 168 Lord Cullen says

“It is essential that the industry redoubles its efforts to provide a system of direct management and training that is secure against ordinary human error whilst endeavouring to reduce the incidence of such human error to an absolute minimum.”

On page 175 Cullen says

“Questions relating to the future of the functions presently discharged by the HMRI as part of the HSE with respect to railways, and the way in which these functions may be or should be discharged in the future, are matters with which I will deal in my report on Part 2 of this Inquiry.”

On page 184 he says

“The Group Standard on SPADS and its associated documentation should be reviewed to ensure that there is no presumption that driver error is the sole or principal cause, or that any part played by the infrastructure is only a contributory factor.”

“The need for root cause analysis is not in dispute”. (He then deals with the HSG 48)

On page 185

“In her statement to the Inquiry Miss Bacon cited the approach to SPADS as an example of the tendency of the Industry “to look at outcomes with insufficient attention to the potential for harm, and at frequencies rather than consequences.”

On page 49 Cullen, when talking about accident investigation, says

“one concern which Inspectors of the HMRI reported was that “no one was in overall control of site safety until eight days after the accident. This resulted in a lack of adequate communication, co-operation, and co-ordination between the various organisations on site”. This prompted them to recommend that in future Railtrack should have suitable consultation procedures for the provision of adequate site health and safety management. The eight days mentioned roughly coincided with the time during which the crash site was a scene of crime under the control of the BTP. Dr. R.J.Smallwood, Deputy Chief Inspector of Railways, HMRI, accepted that there might be a practical problem with this when the police were in control of a site including the cordons.”

In recommendation 35 at page 231 Cullen says

“Persons who investigate and make recommendations as a consequence of SPADS should be trained in the identification of human factors and in root cause analysis. Their competence in these areas should be formally recorded, and renewed by refresher courses. The analysis of SPAD data should be specifically directed to eliciting the part played by human factors and assessing the significance of the hazards against which the signals which have been passed at Danger were intended to afford protection (para 11.31).”

An ingrained rather than “bolted on” safety culture, led by main management, is however the most crucial defence line, since without this commitment, safety remains but an afterthought!

On 20 September 2001 the second part of Lord Cullen’s report was published.

- Railtrack and ATOC jointly with RITC to form task force to ensure skilled and properly trained work force (within six months) (1)
- System authorities require means of enforcing their decisions and adequate finances and powers (2)
- Railway safety to lead research. Adequate funding to come from income related levy of participating bodies (3)
- State of training of contractors to be considered in selection process. Opportunities for development of training (4)
- Safety management strategic leadership team to be established in each rail company (14)
- Management to ensure that elected representatives of the employees have significant role.
- Safety – two way process with staff, trade union involvement (15,16)
- Essential there is robust audit system – “top down” and “bottom up”.
- Recommend statutory duty for duty holders to comply with Railway Group Standards (21)
- Safety product/services suppliers should be accredited, requires further study (24)
- Licensing of drivers and signalmen, revalidated every three years (25, 26)
- Railtrack to have less say (merely input) re. validation of safety cases (27-34)
- Formation of rail industry safety body (40) of new legal entity with power to take binding decisions (49)
- HSE responsibility for accident investigation should go to independent body (57), in January 2003 the Railway Safety Bill was issued, representatives of persons affected should be allowed to attend (64), possibility of appeal against finding of formal inquiry (68), reports to be published (69). Information only to be released to Police by order of the Judge! In July 2002 the HSE reported that 116 of the 295 Cullen recommendations were still outstanding.
- Recently Mr. Justice Morland has dismissed a bid to halt insurers from proceeding with a claim for damages against the HSE over the Paddington rail crash for not carrying out routine duties of inspection and supervision.

1.1 *Gross negligence manslaughter*

The law was somewhat radically altered by the House of Lords Judgment in **Adamako** (1995) 1 AC 171 – please see also in reference to Corporate Manslaughter section as argued by the Prosecution in the Great Western Trains case.

The brief facts were that an anaesthetist in charge during an eye operation failed to notice that an endotracheal tube had become disconnected for a period of approximately six minutes. As a consequence the patient died.

The Defence conceded at trial that the doctor had been negligent but denied that this negligence was so bad it should be deemed criminal.

Lord McKay (L.C.) stated on page 187

“...in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant had been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of a 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...”

“The Jury will have to consider whether the extent to which the defendants’ conduct departed from the proper standard of care incumbent upon him, involving as it must have done, a risk of death (to the deceased) was such that it should be judged criminal.”

The Learned Judge, appreciating the difficulty such a test postulated, went on to say –

“... It is true that to a certain extent this involves an element of circularity, but in this branch of the law I do not believe that it is fatal to its being correct as a test of law for conduct must depart from accepted standards to be characterised as criminal. This is necessarily a question of degree and an attempt to specify that degree more clearly is I think likely to achieve only a spurious precision.”

Therefore in order to convict of the unintentional but unlawful killing of another person the Jury must be satisfied that:

- 1) the Defendant owed a duty of care to the deceased; and
- 2) there had been a breach of this duty of care; and
- 3) the breach was so grossly negligent that the Defendant can be deemed to have had such disregard for the life of the deceased that it should be seen as criminal and deserving of punishment by the State.

It is further suggested that there must be an implicit fourth strand;
That the breach of duty must have been a “substantial cause of death”

In November 1999 two directors of a haulage company were convicted of manslaughter after one of their drivers fell asleep at the wheel and caused the deaths of two other motorists in a seven-vehicle motorway pile-up. The driver’s basic hours were limited to 40, but he often did over 60.

The directors were convicted by the Jury on the basis that they had failed to regulate the driver’s hours to ensure that he did not drive when he was

exhausted. The directors were eventually sentenced to a suspended sentence of twelve and eighteen months respectively. The driver went to prison after pleading guilty.

There has been huge recent concentration on work related driving deaths – watch this space – as Dangerous Drivers are to face harsher sentencing under new guidelines from the Lord Chief Justice. Also recently a Scottish director was fined £2,500 after a court heard an employee was killed after falling asleep at the wheel after excessive hours.

There have been a series of successful Judicial Reviews by bereaved who challenged the authorities for their failure to prosecute parties for manslaughter.

In **DPP ex parte Jones Co.** 23rd March 2000 the High Court said that the failure to prosecute a company who had employed Simon Jones was partly based on irrationality and ordered the CPS to reconsider their decision. In November 2001 the Company and Director were acquitted of manslaughter but fined £50,000 costs for breaches of health and safety.

In April 2000 in the case of **Akthar** the HSE was ordered to investigate the death of a man killed by a forklift. There had been found to be confusion between the HSE, police and local authority on who should investigate the incident. See also **Manning** (Times 19th May 2000) reasons to be given when there is no prosecution. In the case of **Akthar** some six years after his death a builders merchants and a director were fined £100,000.

1.2 *How an investigation may arise*

- 1) The police may be called to the scene of the death, and instigate a prosecution.
- 2) The papers may be referred to the police by the Coroner upon reviewing the case under the Coroners' rules;
- 3) The papers would be referred to the police (or DPP) following an "unlawful killing" verdict;
- 4) The papers could be referred by a regulatory authority such as the C.A.A., H.M.R.I., or the Health and Safety Executive following their investigation into the death.
- 5) It is important to recall that in 1998 a protocol was agreed between the HSE, CPS and ACPO (Association of Chief Police Officers) setting out the principles for effective liaison between them where evidence indicates that the crime of gross/corporate manslaughter may have been committed. In the same protocol details of the arrangement between local authorities and the HSE is also located – it has recently been agreed that the local authorities should be joined to the 1998 protocol.

A revised protocol was published in March 2003; it appears to be working well.

1.3 *Corporate manslaughter*

1.3.1 R v Kite and OLL Ltd. The most salient recent conviction is still that arising out of a canoeing accident at sea in Dorset in 1993 in which four teenage students drowned.

- The brief facts are that eight students, a teacher and two instructors attempted to canoe a distance of about one and a half miles between Lyme Regis and Charmouth.

Very quickly the teacher got into difficulty and one of the instructors stayed back whilst the other instructor and the children continued.

The group drifted out to sea and their canoes quickly became swamped.

The case against Mr. Kite was that as the sole director of OLL, he had the primary responsibility for devising, instituting, enforcing and maintaining an appropriate safety policy. The Jury found he had not done so. Although OLL became the first company to be convicted of corporate manslaughter, and it is thus the landmark case, it must be noted that the company was very small and Mr. Kite was one of only two directors. The Crown had a relatively easy job of showing that Mr. Kite was the "controlling mind". He was originally sentenced to three years imprisonment, which was later reduced to two years on appeal.

- See also **R v Jackson Transport (Osett) Ltd.**

(See **Gateway Foodmarkets Ltd.** [1997] 2 Cr App R 40 CA; see also Section 37 of the Health and Safety at Work Act 1974 – whereby a company officer can be prosecuted if it can be shown that an offence by the company can be attributed to by his own neglect.) (See for example also S.37 of the Aviation Security Act 1982 as amended by the Aviation and Maritime Security Act 1990).

S37 Offences by bodies corporate

- (1) Where an offence under any of the relevant statutory provisions committed by a body corporate is proved to have been committed with the consent or connivance of, or to have been attributable to any neglect on the part of any director, manager, secretary or other similar officer of the body corporate or a person who was purporting to act in any such capacity, he as well as the body corporate shall be guilty of that offence and shall be liable to be proceeded against and punished accordingly.
- (2) Where the affairs of a body corporate are managed by its members, the preceding subsection shall apply in relation to the acts and defaults of a member in connection with his functions of management as if he were a director of the body corporate.

Also greater increase in the numbers of prosecutions of consultants and advisors for bad advice. This trend will continue and accelerate.

- See Section 7 of the Health and Safety at Work Act 1974.
- There are one or two test cases on the way to the Court of Appeal and fines are much bigger now.

1.3.2 **R v Great Western Trains and Larry Harrison**

On the 19th September 1999 a high speed train travelling from Swansea to London passed a signal at red (on SPAD) and collided with a freight train. Seven people died and 151 were injured. The accident further caused about £10 million worth of damage.

At the time of the crash the onboard safety system (the AWS) was not working.

The driver was indicted with seven counts of manslaughter and one count contrary to Section 7 of the Health and Safety at Work Act 1974. GWT were indicted for seven counts of corporate manslaughter and one count contrary to Section 3 of the same Act.

The prosecution argued that there was no longer any need to look for the “directing mind of the company” – (see **R –v- P & O European Ferries (Dover) Limited** [1991] 93 Cr.App.R72) and that the test was purely objective.

In that case the prosecution had been mounted against P & O on the basis of reckless manslaughter. The case was halted by Turner J., who directed acquittals on the basis that none of the seven defendants had been reckless as to the drownings or ignored an obvious and serious risk that the vessels would sail with the bow doors opened.

The Crown further submitted that it was not necessary to identify any person whose acts or omissions amounted to gross negligence (see **R –v-Adamako** above) as the company would be liable if it objectively failed to reach the appropriate standard, i.e. any management failure (or aggregation of failures) that amounted to gross negligence should trigger guilt.

This submission was vigorously rejected by the Learned Judge who said

“...nor, in my judgement, is the doctrine of identification, carefully developed as it has been over the years, now to be confined to a backwater if not supplanted completely. Of course, it is possible to develop the law [in] incrementally to cover new situations. But what the courts cannot do is to legislate under the guise of interpreting the common law. See, e.g. Lord Lowry in **CV DPP** [1996] 1ACI...”

“...But I do not think this is a good reason for no longer having to look for a directing mind in the company to identify where the fault occurred. In my judgement it is still necessary to look for such a directing mind and identify where gross negligence is that fixes the company with criminal responsibility... Accordingly I conclude that the doctrine of identification which is both clear, certain and established in the relevant doctrine by which a corporation may be fixed for manslaughter by gross negligence...”

In his conclusion the Learned Judge went on to say that "...there are many who say that the present state of the law is unsatisfactory However, if the law is to be changed it is up to Parliament to do so. The Law Commission recommended legislation over three years ago, but nothing has been forthcoming. There is little purpose in the Law Commission making recommendations if they are allowed to lie for years on the shelf gathering dust..."

The Judge was referring to the 1996 Law Commission report which annexed a draft bill.

The learned Judge also stated

"Those who travel on high speed trains are entitled to expect the highest standard of care from those who run them. GWT failed to meet that standard and in my judgement they failed to meet it by a greater extent than they had been prepared to admit. Their failure was a significant cause of a disaster that killed 7 people, injured 150 others and caused millions of pounds worth of damage. The lives of many families have been devastated.

The immediate cause of the accident was the passing of a red signal by the driver. But a substantial contributory cause was the fact that the Defendant company permitted the train to run from Swansea to Paddington at speeds of up to 125 mph with the automatic warning system (AWS) isolated.

This case was the subject of an Attorney General's Reference (No.2 of 1999).

On the 15 February 2000 the Court of Appeal wholly endorsed the ruling of Mr. Justice Scott-Baker in its entirety.

The Court concluded by saying "we should add that if we entertained doubt on the matter, being mindful of the observations of Lord Lowry in CV DPP at page 28(c), we would not think it appropriate for this Court to propel the law in the direction which [the prosecutor] seeks.

That, in our judgement, taking into account the policy considerations ... is a matter for parliament, not the Courts. For almost four years the Law Commission's draft bill has been to hand as a useful starting point for that purpose."

See also R v Oaks Millers Ltd. and H.J. Lea Oakes Ltd. (and Mr. Jepson) 20 June 2001 when Mr. Justice Holland directed acquittals for the manslaughter courts on grounds of causation.

See also R v Hubbard and English Brothers Limited (3 August 2001) where the CPS accepted pleas to corporate manslaughter whilst dropping all charges against Mr. Hubbard, the director of the company. Watch this space as the family is very angry, etc.

In R v Horner and Teglgard UK Ltd both the company and managing director pleaded guilty to manslaughter after a worker was crushed to death when a pile of poorly stacked hardwood packs toppled over on top of him. The company was fined £25,000 and the managing director sentenced to 15 months in prison suspended for two years.

R v Kelly (July 2003) a manager of a tourist camp found guilty of manslaughter following the death of a 4 year old in a cesspit.

- See also R v Evromin (see Sentencing section)

1.4 Have the CPS Given Up on the Old Law Yet?

On 10 February 2005, Barrow Borough Council was summonsed for corporate manslaughter. Also charged with manslaughter was one of the Council's employees, a design services manager, who in addition has been identified as its 'directing mind'. In March 2005 there was a judge directed acquittal of the Council.

The prosecutions concern an outbreak of legionnaire's disease in Cumbria in August 2002. The source was traced to a 30 year-old air conditioning unit at an arts centre run by the Council. It appears the maintenance contract to clean the unit where the bacteria developed had been cancelled. Over 150 members of the public were infected. Seven people died.

The corporate manslaughter charges were dismissed in March 2005 as the manager was not deemed to be the directing mind of the Council. There was a hung jury on the manslaughter counts and there is due to be a retrial in 2006.

To convict a company of corporate manslaughter, the prosecution must prove the company's conduct, which led to the deaths, was the conduct of a senior person in the company – the directing mind (also often referred to as the 'controlling mind'). In practical terms this means for a company to be guilty of corporate manslaughter a senior person, normally a director, also has to be guilty of manslaughter.

The difficulty with these cases, particularly against larger companies with layers of management, is proving a causal link between the conduct of the directing mind and the incident that caused death. There have only been a few successful prosecutions to date, all against small companies where it is easier to prove the link.

In **HL Bolton (Engineering) Co Ltd v TJ Graham & Sons Ltd [1957] 1 QB 159** Lord Denning said whether a person is a directing mind depends upon whether they are "directors and managers who represent the directing mind and will of the company and control what it does"

In **Tesco Supermarkets Ltd v Nattrass [1972] AC 153** which concerned a prosecution pursuant to the Trades Descriptions Act 1968, the House of Lords defined individuals as directing minds as

"...the Board of Directors, the Managing Director and perhaps other superior officers of the company....[who]....carry out the functions of management and speak and act as the company".

In the failed prosecution for corporate manslaughter of P & O Ferries that followed the sinking of the *Herald of Free Enterprise* in 1987, the trial judge emphasised the need to prove that the person prosecuted as the directing mind had sufficient responsibility for safety (**R v P & O European Ferries (Dover) Ltd [1991] 93 Cr App R72**).

What the current prosecution against Barrow Borough Council appears to indicate is that in order to overcome difficulties of linking the conduct of a large organisation

with someone senior within it, the prosecution may be attempting to expand the category of persons who can be included in the term 'directing mind'. Also there has been a recent press campaign over Local Authorities and Chief Executives being prosecuted in respect of traffic black spots etc.

In the Hatfield prosecution after a six month trial, the learned Judge threw out the Corporate Manslaughter charges (and individual charges) on the basis that there was no directing mind guilty of manslaughter. Health and Safety convictions were obtained from Balfour Beatty and Network Rail (sub judice).

See also: **EL Anjou v Dollar Land Holdings** [1994] 2 All ER 685 and **KR and Others v Royal Sun Alliance** [2006] EWCA Civ 1454.

1.5.1 Conclusion

The attitude of the Government, CPS and Health and Safety Executive is hardening. As one senior official recently said "... A jail sentence could help concentrate the minds of employees who might not be carrying out their duties under health and safety laws ..."

This mirrors the attitude of the United States to deterrence where one senior District Attorney recently said "... one of these prosecutions is worth 500 as far as determent is concerned".

The time has come to face the facts that the times are changing and that there is soon to be nowhere to hide, even for multi jurisdictional plcs who do not place health and safety a top priority.

There is, however, one serious risk to the introduction of the proposed legislation, namely that the very opposite of what may be intended may become the reality – that being the driving of safety underground. We shall have to wait and see and hope that improved safety and increased accurate confidential reporting is not sacrificed on the altar of political pragmatism.

- See also Turnbull Guidelines
- See also private members bill on Health & Safety Offences Bill

2. HEALTH AND SAFETY AT WORK (SOME EXTRACTS)

Section 2 of the Health and Safety at Work Act ("HSWA") states:-

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

Section 3 of HSWA states:-

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

The important words are "reasonably practicable".

The test as to what is “reasonably practicable” is set out in the case of **Edwards v National Coal Board [1949] 1 AER 743**

“reasonably practicable” is a narrower term than “physically possible” and seems to me to imply that a computation must be made by the owner, in which the quantum of risk is placed on one scale and the sacrifice involved in the measures necessary for averting the risk (whether in money, time or trouble) is placed in the other; and if it be shown that there is a gross proportion between them the risk being insignificant in relation to the sacrifice the Defendants discharge the burden on them.”

In relation to prosecutions of individuals **Section 7(a) HSWA** requires every employee while at work

“to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work”.

The risk assessment has to be reviewed if there is any reason to believe that it is no longer valid or if there has been any significant change in the matters to which it relates. If the employer employs five or more people, then the “significant findings” must be recorded.

- See also **R v Board of Trustees of the Science Museum [1993] 1 WLR 1171**.

The HSE have recently launched a Consultation Exercise regarding its proposal to introduce a compulsory duty for all companies and organisations to investigate and record all reportable work related accidents, ill-health or “near misses”, including current non-reportable accidents and ill health.

The HSE has also recently issued guidelines confirming that health and safety matters should be referred to in companies’ annual reports. This will be compulsory for all companies employing more than 250 employees by 2004.

- See also **Davies v HSE [2002] EWCA 18th December 2002** and Section 40

3. RISK ASSESSMENTS

Under the **Management of Health and Safety at Work Regulations 1999** (which came into force on 29th December 1999 and supersedes the 1992 regulations of the same title) (“**MHSWR**”), companies must carry out risk assessments of workplace hazards and put in place the necessary preventative measures.

The general obligation to carry out risk assessments, the centrepiece of the Regulations, is set out in **Regulation 3** of the **MHSWR** and states:-

“(1) Every employer shall make a suitable and sufficient assessment of –

- (a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and*
- (b) the risks to the health and safety of the persons not in his employment arising out of or in connection with the conduct by him of his undertaking*

for the purpose of identifying the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions.”

In 1998 the HSE reported that over 40% of all companies experienced serious problems when carrying out general risk assessments. The report said –

“... The problem reported most frequently was identifying the hazards, suggesting that organisations have difficulty with fully understanding what they should be looking at in the risk assessment”!

In my view, the prosecution will in the future seize on any failure to adequately risk assess to justify prosecutions for corporate and gross negligence manslaughter. (See also Cullen Report at page 114 et seq)

4.0 HEALTH AND SAFETY

On 7 June 2000 the Government and Health and Safety Commissions announced their ten year blueprint for safety in a document entitled “Revitalising Health and Safety Strategy Statement”. John Prescott said at the launch “Health and Safety is a priority issue for those at the top of all corporations and they must be prepared to face the consequences of ignoring the law; in future that could well mean prison.”

HSC chairman, Bill Calaghan, also said “Health and Safety should be a core requirement of business activity, not an inconvenient ‘add on’ ... those who cannot manage health and safety cannot manage the need to create a positive health and safety culture which sees business going beyond the statutory minimum”.

“The specific targets stated are to;

- reduce the number of working days lost from work-related injury and ill-health by 30 per cent by the year 2010 (a decrease of 7.5 million days on current estimates);
- reduce the incidence of people suffering from work-related ill-health by 20 per cent by the year 2010 (80,000 fewer cases on current estimates);
- reduce the rate of fatal and major injury accidents by 10 per cent by the year 2010 (30,000 fewer cases on current figures);
- achieve half of each improvement by the year 2004.”

The Government targets are to be met by a 44 point action plan which includes:

- (1) Tougher maximum penalties which include imprisonment and higher fines;
- (2) New types of sentences including fines linked to turnover, prohibition of bonuses, supervision of managers without pay, suspended sentences pending remedial actions, compulsory health and safety training, community service, etc.
- (3) Private prosecutions in England and Wales without the consent of the DPP (overriding S.38 of the Health and Safety at Work Act).

- (4) A directors' code of practice to ensure that a named person in every company will have a statutory responsibility for health and safety matters to protect all workers.
- In January 2003 Mr Calaghan said on reviewing the latest figures ...“My first reaction is that these figures show very little change”.

4.1.1 *Health and Safety at Work (Offences) Bill*

There have been attempts to introduce this in the past by way of a private member's bill. There is currently another attempt being made again.

- increase in maximum fines for breaches in the lower courts from £5,000 to £20,000;
- makes imprisonment an option for Health and Safety at Work Act breaches – six months for summary offences and two years on indictment – please note this is currently on hold.

- 4.1.2** See also the HSC guidelines on enforcement published on the 14 August 2001 which stress the increased number of prosecutions of directors and companies sought.

The latest version of the guidelines states “Enforcing Authorities should identify and prosecute or recommend prosecution of individuals if they consider that a prosecution is warranted. In particular they should consider the management chain and the role played by individual directors and managers and should take action against them where the inspection or investigation reveals that the offence was committed with their consent or connivance, or to have been attributable to neglect on their part, and where it would be appropriate to do so in accordance with this policy. Where appropriate, authorities should seek disqualification of directors under the Company Directors Disqualification Act 1986.”

Bill Callaghan said in October 2001 “Responsibility for health and safety issues lies directly at the door of directors and their representatives throughout the management chain. The HSC has clear health and safety guidance on what it expects from the board room. I strongly advised employers to follow it.”

This should perhaps be read against a backdrop of further raft of future changes such as to the Control of Asbestos Regulations and preventing workplace transport accidents where many companies are very vulnerable.

5. HUMAN ERROR AND THE LAW

The HSE definition of human factors is:-

“Human factors refer to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety (HSE 1999 - HSG.48).

Human factors therefore consider three main aspects:-

- (1) the job – e.g. task, workload, procedures, etc;
- (2) the organisation – e.g. culture, leadership, communications, etc;
- (3) the individual – e.g. skills, personality, etc.

There is no doubt that in the future the prosecution authorities will pay much greater heed to what companies have done, or failed to do in this area.

In a way of attempting to provide a ‘smorgasbord’ of different things to consider, please find below a few extracts of unrelated but not entirely unconnected extracts from different sources – all of which in my view are highly relevant to some of the various industries you represent today. Avoid them at your peril!

For instance, **Mashour** (1974) said in his book Human Factors:-

“... it is when man is required to work rapidly and accurately with tools and machines in man-made environments that human limitations in processing information (e.g. detection and attention) cannot always cope with the demands of the tasks and may even be critical for safety”

In the HSE publication “Reducing Error and Influencing Behaviour” (**HSG48**) the following extracts are of particular importance in my view:-

At page 4 **HSG48** asks the question as to why there should be an interest in human factors at work. It states:-

“Careful consideration of human factors at work can reduce the number of accidents and cases of occupational ill-health. It can also pay dividends in terms of a more efficient and effective work force. Accidents can occur through people’s involvement with their work. As technical systems have become more reliable, the focus has turned to human causes of accidents. It is estimated that up to 80% of accidents maybe attributed, at least in part, to the actions or omissions of people. This is not surprising since people are involved through the life cycle of an organisation, from design through to operation, maintenance, management and demolition. Many accidents are blamed on the actions or omissions of an individual who was directly involved in operational or maintenance work. This typical but short-sighted response ignores the fundamental failures which led to the accident. These are usually routed deeper in the organisation’s design, management and decision making functions.”

Again at page 4 **HSG48** poses the question that it is simply just about telling people to take more care. Of this the guide states:-

“No. It is quite wrong to believe that telling people to take more care is the answer to these problems. While it is reasonable to expect people to pay attention and take care at work, relying on this is not enough to control risks.”

In relation to human failure and accidents (as quoted earlier) **HSG48** at page 7 states:-

“Over the last 20 years we have learnt much more about the origins of human failure. We can now challenge the commonly held belief that incidents and accidents are the result of a “human error” by a worker in the “front line”. Attributing accidents to “human error” has often been seen as a sufficient explanation in itself and something which is beyond the control of managers. This view is no longer acceptable to society as a whole. Organisations must recognise that they need to consider human factors as a distinct element which must be recognised, assessed and managed effectively in order to control risks.”

In relation to investigating the causes of accidents **HSG48** at page 11 states:-

“After an accident involving human failure there may be an investigation into the causes and contributing factors. Very often little attempt is made to understand why the human failure has occurred. However, finding out both the immediate and the underlying causes of an accident is the key to preventing similar accidents through the design of effective control measures.”

In the HSE publication “*Reducing Error and Influencing Behaviour*” (**HSG48**) the following extracts are of particular importance in my view.

From **HSG65** – Successful Health and Safety Management Section on page 9, it states:-

“accidents, ill health and incidents are seldom random events. They generally arise from failures of control and involve multiple contributory elements. The immediate cause may be a human or technical failure, but they usually arise from organisational failings which are the responsibility of management. Successful policies aim to exploit the strengths of employees. They aim to exploit the strengths of employees. They aim to minimise the contributions of human limitations and fallibilities by examining how the organisation is structured and how jobs and systems are designed.

*Organisations need to understand how human factors affect health and safety performance. These are explained in more detail in the HSE publication **HSG48** ‘Human Factors in Industrial Safety’ (see above).”*

See also “Improving Maintenance – a Guide to Reducing Error” – HSE October 2000.
See also page 26 of these notes in relation to refuelling of aircraft.
See also Cullen Report.

Some recent examples:

Watford 8 August 1996

Eastcote 31 December 1996

Southall 19 September 1997

Paddington 5 October 1999. There is still an ongoing police investigation. Late last year the police announced that there would be no prosecution of Thames Trains for

corporate manslaughter. Thames was fined a record £2million this month for Health and Safety breaches.

Hatfield 17 October 2000 (sub judice) – charges in July 2003 of Network Rail and Balfour Beatty and individuals.

Potters Bar (sub judice). A recent announcement has been made that the lead in the investigation is being passed from the Police to the HSE. Thus manslaughter charges are unlikely

Libyan coast crash – January 2000, where 22 people died – official report says that the first officer and co-pilot were allegedly so busy talking about how to fly different aircraft that they failed to switch on the anti-icing system for the engines. As it melted on coming into land, it flooded into the engine compartment of the twin engined shorts SD 360-300 and the engines cut out.

Concorde crash - Paris 2000.

World Trade Centre – September 2001.

Although sub judice, the recent tragic accident on the 9th February when the USS Greenville rammed the **Ehime Maru** whilst demonstrating an emergency ascent manoeuvre off the Hawaiian Islands to a group of civilian visitors raises other issues. Apparently two civilians were at certain control positions at the time of the accident. The US Navy, however, say they did not cause the accident.

The US Defence Secretary, Donald Rumsfeld, has called a ban on civilians taking the controls of all US military vehicles, ships and aircraft (information from BBC WWW).

See also the Southall and Ladbrooke Grove (“Paddington”) Public Inquiries.

Please see the Cullen Report, i.e. why did Michael Hodder (the dead Thames Trains driver, who was my client at the Inquiry) miss and then SPAD SN.109. What were the organisational factors (and failings) that were involved?

In most instances of human error, the blaming of front line workers is an almost futile exercise and concentration on this aspect as opposed to organisational and/or engineering investigation and probing is a recipe for disaster in the future (see ante).

6.0 SENTENCING

In the leading case of **R v F.Howe & Sons (Engineering) Ltd.** [1999] 2 All ER 249 the Court of Appeal (on the 6 of November 1998) set down guidelines for the sentencing of offences contrary to the Health and Safety at Work Act 1974.

The brief facts were that a 20 year old employee of the appellant was electrocuted whilst cleaning the appellant’s factory which had been shut down for this purpose. He died.

An electric vacuum cleaner known as a “Freddy” was being used at the time to suck up water from the factory floor. The cable to the machine became trapped between

the wheels and floor and was consequently damaged and became live. The employee holding it was electrocuted.

For a number of technical reasons the company failed to ensure that the safety at work of its employees had been safeguarded “so far as was reasonably practicable”, and the lack of a system to check its electrical equipment fell far short of the appropriate standard in this case. “... the tragedy that befell Giles Smith was unfortunately an accident waiting to happen...”

Mr. Justice Scott Baker said that “...it was impossible to lay down any tariff or to say that the fine should bear any specific relationship to the turnover or net profit of the defendant. Each case must be dealt with according to its own particular circumstances.”

The aggravating factors are:

- (1) how far short of the appropriate standard the defendant fell;
- (2) whether there was a death; and
- (3) whether there had been a deliberate breach of the health and safety legislation with a view to maximising profit which would seriously aggravate the offence (as would a failure to heed warnings).

The mitigating features include:

- (1) prompt admission and plea;
 - (2) steps to remedy deficiencies; and
 - (3) a good safety record.
- This will lead to higher fines in the Crown Court, although in the Court of Appeal the fine was reduced from £48,000 to one of £15,000.
 - See also **R v Rollco Screw and Rivet Company Limited & Others** [1999] 2 Cr.App R(S)436 which deals with the time of payment of fines.
 - See also **R v Brintons Ltd.** [Court of Appeal 22.6.99] (failure to prevent the exposure of employees to asbestosis – fined £100,000).
 - See also **R v Associated Octel Ltd.** [1997] Cr.App. R(S)435 on prosecution of costs. The Court must look at the total sum it was minded the defendant should pay and then consider the impact upon him.
 - In the **Southall** case when sentencing GWT Mr. Justice Scott Baker said that they had failed to meet the required standard of care of its passengers and that this failure was a “significant cause” of the crash. When sentencing them to a £1.5 million fine the Learned Judge stated that the fine was imposed to reflect the following:
 - (a) “the extent to which GWT fell short of the standard required of them and the risk that was thereby created. In my view it was a serious failure.

- (b) the extent of the disaster and in particular the number of people killed and injured.
- (c) The need to bring home the message to GWT and others who run substantial transport undertakings that vigilance is required to ensure that accidents of this nature do not occur. In my judgement a substantial fine is required to emphasise this to a large and profitable enterprise such as the defendant.”
- See also **R v London Underground Ltd.** [27.7.99] when London Underground was fined £300,000 for a breach of Section 3 of the Health and Safety Act and a failure to risk assess under the Regulations. In essence a lady fell between the train and platform of a Piccadilly Line station. At the station in question a third of the platform was “blind” to the driver using the driver’s monitor upon which he had to rely to ascertain whether it was safe or not to proceed.
 - See also **R v Balfour Beatty** who were fined £1.2 million for the collapse of the underground rail tunnel at Heathrow Airport during construction (and £500,000 for a derailed train in March 1999).
 - See also **Basingstoke and Dean Borough Council v Sainsburys** who were fined £425,000 for six breaches of the health and safety offences and other associated legislation.

The brief facts were that a worker was killed by a forklift truck that toppled over and crushed him while he was inspecting it. The safety cut-off had been deliberately disconnected.

Mr. Justice Kay said”... the story is a picture of working procedures that dates back to the dark ages ...”

In January 2001 **South East Galvanisers** were fined £150,000 plus £35,000 costs after a worker who had been servicing a crane fell through a piece of plywood which was being used to temporarily cover an opening in a metal platform into a vat of molten zinc heated to about 450oC. He lived for six hours. The Judge said “This accident is almost too horrible to describe. I believe that it was utterly avoidable.”

In February 2001 **Doncaster Borough Council** were fined £400,000 and ordered to pay £30,000 costs following the death of a contractor by electrocution when working at the Council’s headquarters. Allegedly, Council officials were aware that certain wires were exposed and dangerous, but did not warn the contractor who was repairing an air-conditioning unit. The Judge stated that if the Authority had been profit making with annual profits of £10 million, he would have fined them £10 million!

In August 1999 **BOC** were fined £300,000 and ordered to pay £58,000 after an employee was killed and another injured when pure methane and oxygen were accidentally mixed together.

In September 1999 **Friskies**, the pet food manufacturers, were fined £600,000 (plus costs) after an employee died when carrying out welding work in a metal silo (reduced to £250,000 on appeal).

In March 2000 the owner of a small gardening company was convicted of manslaughter when an employee died when transferring waste into a tip. He was sentenced to twelve months imprisonment suspended for two years.

Also in March 2000 **Railtrack** were fined £150,000 for the death of a train driver (Section 3). The manslaughter charge was dropped.

R v Hall & Co.Ltd. [1999] 1 Cr App R(S) 306 – Section 2 – fatal accident when a worker was killed after being run over by a lorry in a builders' yard. No designated pedestrian area or safety features. There was also no risk assessment. The fine of £150,000 was upheld on appeal.

See also **R v Cardiff City Transport Services** (Court of Appeal 22 May 2000) – similar facts except in a bus depot when a driver ran in front of a bus and was killed. No vehicle or pedestrian risk assessment had been carried out. The £75,000 was reduced on appeal to £40,000.

In **R v Abdul Majeed** a property developer was jailed for four months after failing to comply with an improvement notice in relation to a dangerous building.

In **E A v Milford Haven Port Authority** the record fine of £4 million (plus £825,000 costs) was reduced to £750,000 on appeal (Court of Appeal 16 March 2000). This concerned the 72,000 tonnes of oil leak from the “Sea Empress” under the Water Resources Act 1991.

CAA v. British Midland unreported July 26, 1996.

British Midland were fined £150,000 and ordered to pay £25,000 costs for two breaches of the Air Navigation Orders 1989 after pleading guilty at Luton Crown Court.

An emergency landing was forced after both engines nearly ran out of oil. The leaks were caused by a “crass act of negligence” by a fitter who failed to replace the engine covers after a maintenance check. This error had been compounded by a senior supervisor failing to run the engines after the test. Both men had been dismissed.

His Honour Judge Rodway stated “It is only through the vigilance and skill of the pilot and his crew that the dramatic sudden loss of oil pressure was noticed and the aircraft was able to land safely at Luton. Had they not noticed, the engine very shortly after would have, if not seized, suffered such a dramatic loss of power that the aircraft would have crashed with a very high probability of killing all 189 on board”. He further stated that the penalty was imposed “...to make clear to the industry that any cuttings of corners is simply not worth the candle. The public must have confidence that companies who run airlines are taking all proper and necessary steps to ensure safety”.

These words should perhaps be read against the excellent document recently published in October 2000 by the HSE entitled “Quantified Risk Assessment of Aircraft Fuelling Operations” authored by Balfour Beatty. As it states on page 5 “a turnaround can involve approximately 38 people (not including air crew) and 30 pieces of equipment”.

See also CAP74 and CAP434. In relation to CAP74 at page 29 of the document, it was stated that “...During a three hour visit to a major UK airport the following procedural violations were noted from observations of seven turnarounds:

1. None of the baggage belt drivers used a banksman when reversing.
2. A belt loader was reversed to an excessive distance, when it would have been possible to drive forwards after reversing a smaller distance.
3. A fueller jammed the dead man’s handle in place on a refueller vehicle (rather than holding on to it) and moved away from the vehicle.
4. A fueller did not attach a lanyard to the pit valve during hydrant fuelling.
5. A flag was not positioned in the pit but left lying on the ground.
6. A flag was not positioned in the slot on the hydrant, but left at an angle in the pit.
7. Several vehicles were moving faster than 20 mph around the apron.
8. Several vehicles were driven faster than 5 mph, and in some cases in reverse, close to the aircraft.

The report sets out at page 125 a series of recommendations to be implemented. These centre on the need for a much greater demarcation of safety responsibilities for turnaround activities. To these perhaps the guidance set out by the HSE for personal protective equipment: high visibility clothing for aircraft workers should be added.

“... Turnround often has to be carried out to a tight deadline. Frequently, all the tasks involved have to be carried out simultaneously. They are often carried out by a number of different companies, who are usually contracted to a number of different airlines or aircraft operators. Some airlines have divisions or subsidiaries which carry out parts of the turnround. At smaller airports some of the workers involved may be employed by the airport or aerodrome operator. At larger airports this is rarely the case.

Whatever the set-up at a particular airport or airline, it is almost certain that a substantial portion, if not all, of the turnround will be carried out by contractors. Some organisations still do not accept their responsibilities for the contractors working for them.

In this booklet, the term “contractors” includes service providers involved in aircraft turnround, not just those companies involved in construction or building maintenance.

Often there is failure to properly co-operate and co-ordinate activities during turnround. Because there are often many companies all working around the aircraft at the same time, any failure to accept responsibilities and any weaknesses in co-operation and co-ordination

are likely to increase the risks of health and safety ('risk' being the chance, great or small, that someone will be harmed by a hazard)."

The proposed health and safety and manslaughter legislation, as discussed previously, will have a fundamental effect on certain major Airlines who still tend not to fully appreciate that they have criminal responsibility for their contractors' and sub-contractors' omissions or commissions.

See also the publication entitled "Improving Maintenance: a guide to reducing human error" published by the HSE in October 2000 – as discussed earlier.

R v Fresha Bakeries and Harvestime Limited and Others (July 2001) – a total of £628,000 in fines and costs was imposed after two maintenance workers died from heat exposure after being trapped inside an industrial oven. The companies are appealing the fines and costs order.

R v Costain plc (July 2001) – a fine of £200,000 was imposed after a subcontractor was crushed to death by a vehicle at a building site in South Wales.

R v Evromin (November 2001) (Simon Jones case) dating back to 1998 fined £50,000 and costs for health and safety breaches (huge pressure group impact)

R v Costain and Yarm Road Ltd (November 2001) (Avonmouth Bridge collapse). Both fined £250,000 for breaches of Section 2 and costs of about £250,000 each.

Colthorp Broad Mill Limited (January 2002) re. sentence guidelines.

London Underground – fined £225,000 for paying "lip service" to health and safety issues (trackside workers at danger).

B.P. – fined £1 million for no fatalities – just risk at their Grangemouth plant.

Hammersmith and Fulham – December 2001. Fined £350,000 for a faulty boiler that killed two tenants.

R v. Dean – sentenced to 18 months imprisonment or manslaughter after a kiln collapsed killing two workers. The company was also fined £125,000 plus costs.

R v Brian Kunz and Others. A property developer was fined a total of £195,000 after pleading guilty for breaches of the CDM Regulations. A labourer was killed when he was struck by falling masonry during demolition.

R v Birmingham City Council was fined £150,000 plus costs after three people were killed when a tree it was responsible for fell on top of two cars.

R v St John Ambulance (2003) – fined £110,000 fines and costs for breaches of Section 3(1) after a volunteer was killed when he was struck by a powerboat during an unsafe water rescue training exercise.

R v Helmrich (2003). The Health and Safety manager of Fatty Arbuckles Ltd was personally fined £3,000 plus costs after being convicted of failing to put in place a suitable safety audit management system. A 17 year old consultant was electrocuted by a plate warming machine with faulty wiring.

R v London Borough of Havering (2003) – fined £75,000 plus costs after a six year old girl died in a swimming pool under their control.

- Also note Rotherham Borough Council has been charged for a death of an 8 year old in a leisure centre pool.

R v Nestle (2003) - fined £220,000 and costs after an electrician was electrocuted whilst working at the plant.

See **R v. DPP ex parte Manning** (2000) 3 WLR 463 states also duty on CPS to give reasons for a decision not to prosecute in connection with a death in custody.

Section 40 was reviewed by the Court of Appeal in December 2002 – See **R v Davies and Tanways Ltd** where the Court of Appeal held S.40 was not foul of Article 6.

Also the High Court has noted that local authorities can ask questions under S.20 in writing and not need to do so in person – see **R v ex.p. Wandsworth Borough Council (May 2003)**.

Ford Motor Company were fined £300,000 after a contractor died at their plant in a vat of paint emulsion.

Earls Court Ltd and Unusual Rigging Ltd were fined £80,000 and £20,000 respectively at the Old Bailey for a rigger falling from height. Some months earlier another worker had been killed in a similar incident for which Earls Court had been fined £70,000.

Dalubrick Ltd and its officers were fined £245,000 in August 2004 in relation to the removal of asbestos following and HSE investigation. Two directors were also fined and disqualified from holding any directorships for two years. This is an increasing trend.

The **Managing Director of Nationwide Heating Systems** were sentenced to 12 months imprisonment after being found guilty of manslaughter after an apprentice heating engineer died in an explosion at a boat yard.

The **Corporation of London** was recently fined £80,000 after an 84 year old man was knocked down by a reversing lorry in Hampstead Park.

Fines are rocketing up and amount more and more to the equivalent of one year's profit, especially in smaller companies. This will soon also be the case in larger companies.

R v Thames Trains 5 April 2004 Central Criminal Court. This related to the Ladbroke Grove Train Crash where one of the company's drivers passed a red signal and collided with another train killing 31 people. It was accepted that the signal passed by the driver was 'infamous' having been passed at danger 8 times previously in six years. However the company accepted that there were deficiencies in its training (the driver was newly qualified) and that it had failed to warn him that the signal was a dangerous one.

The company was fined a record £2 million pounds with a cost order of £75,000. Mr Justice Bell said the fine "could not put a value on the lives lost". He added that it should have a real economic impact on the company and be a reminder to it and other rail companies of the "paramount importance of safety and prompt attention to any identifiable risk".

R v Balfour Beatty and McGinley September 2004 – Both Defendant and Companies fined in excess of £400,000, including costs, after a railway worker was killed whilst walking on a track.

R v Michael Roberts – Sentenced to 12 months for manslaughter after pleading guilty and giving evidence against his superiors. Mr Roberts drove an HGV when knowing that the brakes were faulty. The Attorney General appealed on the basis that the sentence was too low but it was upheld on appeal. The Directors were acquitted of manslaughter but found guilty of conspiring to pervert the course of justice by falsifying maintenance records.

R v P & O Ferries – In November 2004, and against a trend of upward figures, the Court of Appeal reduced the fines from £250,000 and £50,000 to £200,000 and £25,000 respectively. The Court of Appeal felt that the very early plea should be rewarded. The accident arose when a lorry collided with an employee whilst reversing in poor light in the evening. It should be noted however that the Court of Appeal did not award the Company the costs of the appeal!

In August 2005 **Transco plc** were fined a record £15 million for an explosion that killed a family of four in 1999. No separate order of costs was made as in Scotland the prosecution are not allowed to seek costs.

In October 2005 **Balfour Beatty** were fined £10 million plus £300,000 costs. **Network Rail** was fined £3.5 million plus £300,000 costs. This was reduced to £7.5 million by the Court of Appeal. (See The Times Law Report dated 19 July 2006 and [2006] EWCA1586.

In October 2005 **Transco plc** were fined £1 million plus costs for a gas explosion where one person died in a block of flats. This was reduced by £750K by the Court of Appeal in March 2006 **R v Transco [2006] EWCA Crim 833**.

R v Transco High Court of Scotland 25th August 2005

The company was fined £15 million after a six month contested trial, the highest fine ever (there was no order for costs as this was a Scottish case). Transco became the first (and only) corporation to be charged with culpable homicide (Scotland's equivalent to charging a company with manslaughter). However this charge was dismissed on 3rd June 2003.

The prosecution for a breach of section 3 HSWA was in relation to the company's failure to maintain a leaking gas main and keep accurate records which resulted in an explosion killing a family of four in their home. An iron gas main was corroded and leaking and by December 1999 the gas had been escaping into the family's home, leading to a build up to form a highly explosive atmosphere. The case concerned long term shortcomings.

In sentencing the company the judge stated:

"...the company have chosen to attempt to blame the explosion on an internal pipe leak (ie something for which they are not responsible) despite overwhelming evidence to the contrary.....That aspect of the defence by the company serves only to demonstrate that the corporate mind of Transco has little or no remorse this tragedy....."

.....Transco were at the time, and still are, a substantial public company. In 1999 they had a turn over of almost five billion, pre tax profits of over one billion and were paying dividends of over three hundred million...."

....I do take into account the prompt and costly action which Transco did take after the explosion to rectify the problem....I also take into account the safety record of the company and the fact that they have spent billions on mains replacement over the years. I also take into account the attitude of the HSE....that in general the company does have a responsible attitude to health and safety."

R v Balfour Beatty Rail Infrastructure Services Ltd and Network Rail Old Bailey 7th October 2005

This prosecution related to the Hatfield train derailment of 2000 when a rail suffering from gauge corner cracking shattered into many pieces causing the death of four passengers. Balfour Beatty Rail Infrastructure Services Ltd, the maintenance contractor, was fined £10 million and Network Rail, the infrastructure owner, was fined £3.5 million. Both companies were ordered to pay costs of £300,000 each.

The trial began on 31st January 2005 with Balfour Beatty Rail Infrastructure Services Ltd being prosecuted for manslaughter and breaching section 3 HSWA, six individuals (four employees of Network Rail and two of Balfour Beatty Rail Infrastructure Services Ltd) for manslaughter and breaching section 7 HSWA, and Network Rail for breaching section 3 HSWA (the manslaughter charges having been dismissed prior to trial).

Balfour Beatty Rail Infrastructure Services Ltd pleaded guilty on 18th July 2005 to breaching section 3 HSWA after the manslaughter charges were dismissed against the company (and also against all the individuals) at the conclusion of the prosecution's case.

On 6th September 2005 (there having been a three week break in August), the jury returned verdicts of Not Guilty against the individual defendants in relation to the health and safety offences and guilty against Network Rail for breaching section 3 HSWA.

On sentencing Balfour Beatty Rail Infrastructure Ltd's failure to carry out visual and ultrasonic inspection adequately over a 21 month period the trial judge described this as "*the worst example of sustained, industrial negligence in a high risk industry I have seen*" and "*lying at the top of the scale*". Network Rail was sentenced upon its failure to adequately manage the maintenance contractor. The judge said the company's failures "*were lamentable, but of a lower order by a clear margin*".

The rail in question had been programmed for renewal which had not occurred and the new rail had lain beside the track for many months. The renewal was the responsibility of another contractor. As described earlier Network Rail was not sentenced for this failure as it was not part of the prosecution's case. The Court of Appeal disagreed with this approach.

On appeal (*R v Balfour Beatty Rail Infrastructure Services Ltd* [2006] EWCA Crim 1586, Times Law Reports 19th July 2006 – judgement given on 5th July 2006) the maintenance contractor's fine was reduced to £7.5 million because of the disparity of sentence between its fine and that of Network Rail's.

The Court of Appeal said that the disparity between the sentences imposed on two defendants is not an automatic reason for reducing a sentence but relied upon the test set out in *R v Fawcett* (1983) 5 Cr.App.R.(S.) 158 which it said had been satisfied:

"...would right thinking members of the public, with knowledge of the relevant facts and circumstances, learning of this sentence consider that something had gone wrong with the administration of justice."

The Court of Appeal went on to explain its reduction in sentence:

"To restore appropriate proportionality between the two fines would require Balfour Beatty's fine to be reduced to a level at which it failed to give proper effect to the [Howe principles]. We do not consider that this would be right. Those principles do, however, provide more assistance in identifying the lower limit of an appropriate range of fine than the upper limit. They leave the sentencing judge a wide discretion as to the level at which to pitch the fine. The fine of 10 million on Balfour Beatty was severe. We consider that there is scope for a reduction in the interest of proportionality which will still do justice to the applicable principles and, in particular, to the victims of the Hatfield disaster. We have decided that Balfour Beatty's fine should be reduced to £7.5 million, thereby reducing the disparity between its sentence and that of [Network Rail]." *R v Network Rail Blackfriars Crown Court 30th March 2007*

Network Rail was fined £4 million for its predecessor's role in the Ladbroke Grove train crash of 1999 when the driver of the Thames Train passed signal SN109 at red and collided with a First Great Western train travelling in the opposite direction on a section of track that was bi-directional. As a consequence 31 people died.

Following the crash there was a public inquiry before Lord Cullen in which he was very critical of Railtrack.

Earlier on 5th April 2004 at the Old Bailey Thames Trains were fined £2m for its failures in respect of the training of the driver who had qualified only 13 days before the crash.

The judge in that case stopped short in finding the failures of Thames Trains had been causative of the crash. SN109 had been passed at red (known as a SPAD – signal passed at danger) on eight previous occasions in six years. The judge said:

"if a signal has been passed at danger on several occasions by different drivers, the common factor is the signal, not the driver"

Network Rail admitted that Railtrack's failures were causative of the crash. It also admitted an exposure to risk of four years in relation to the SPAD problem in the Paddington area as a whole.

The judge when sentencing made the following comments:

"Railtrack conceded before Lord Cullen, realistically in the face of powerful evidence, that its failure to carry out adequate root cause analysis of SPADs had been "systemic and unacceptable", with investigation not going beyond the relevant driver's acceptance of responsibility. Mr Sweeney QC made it clear that Network Rail do not seek to resile from that concession now. He also did not seek to quarrel with Lord Cullen's conclusion that there was a serious and persistent failure to deal with the recognised problems of SPADs in the Paddington area in a prompt, proactive and effective manner. In particular Lord Cullen concluded that:-

"The failure to have signal sighting committees convened was persistent and serious. It was due, as Counsel to the Inquiry submitted, to a combination of incompetent management and inadequate process, the latter consisting in the absence of a process at a higher level for identifying whether those who were responsible for convening such committees were or were not doing so. If a signal sighting committee had been convened, they would have found that SN109 was unacceptable, not merely because of its non-compliance with the relevant Group Standards, but also of the inferior quality of its visibility. There would have been changes, although it is not possible for me to specify what they would have been. It might well have led to the replacement of gantry 8 and its Down signals."

I adopt those findings of Lord Cullen. The aspect of the case which to my mind renders Railtrack's failures substantially graver than those of Thames Trains is that they persisted despite the series of SPADs at SN109, of which the Bunney SPAD, involving a Great Western train, was the sixth and by far the most serious: Mr Mott QC was justified in describing it as a dress rehearsal for the disaster of 5 October 1999. Thames Trains' failures in instruction were the subject of a warning report in 1998 but there is no equivalent in their case of a series of adverse incidents which it was their responsibility to analyse.....

The sentence imposed on a company such as this Defendant can only be a fine. The fine must be sufficient to be a constant and lasting reminder to the management of the company and to others involved in the railways of the

paramount importance of safety and to prompt attention to any identifiable risk. It must mark the seriousness of the risk involved in the breach of duty, a seriousness underlined by the disastrous consequences to which I have referred; and must also reflect the mitigation to which I have referred, including the guilty plea. No fine, of any amount, can put a value on the many lives lost or the continuing stress and pain of those bereaved or injured by the disaster.

Taking all the aggravating and mitigating factors I have mentioned into account, if I were starting from scratch in sentencing Network Rail, I would impose a fine of £5 million. That would, however, create too great a disparity between them and Thames Trains who have already been sentenced and who were fined £2 million. In the light of the factor which I have described as the persistence of the breach, Network Rail should be liable to a fine twice that of Thames, but no more. The fine in this case will therefore be £4 million. In addition Network Rail must make a contribution to the costs of the prosecution, which has been agreed between the parties in the sum of £225,000.

7.0 HUMAN RIGHTS ACT 1998

The Human Rights Act 1998 (“HRA”) came into force on 2nd October 2000.

The Act “gives further effect to” the European Convention for the protection of Human Rights and Fundamental Freedoms (“the Convention”) in domestic law:

- The Act has been given partial effect since 22 May 1999, in Scotland, by virtue of the Scotland Act 1998. The recent Scottish decisions are a good precursor to what we can reasonably expect post October.
- As a result of the Act Convention Rights can now be directly relied upon, argued and enforced in the UK Courts and tribunals at all levels.
- The acts or omissions of public authorities can be challenged as part of any legal proceedings, by judicial review or as an entirely new course of action under the Act.
- Once all domestic remedies have been exhausted in the domestic courts, an appeal still lies to the European Court of Human Rights (“ECHR”) in Strasbourg. Decisions of the ECHR are final and binding on member states.
- The Act will provide all parties with a versatile tool and potent complement to a legal armoury to support existing arguments or create entirely new challenges.
- To properly advise and represent clients, lawyers will have to be fully familiar with the provisions of the Act and ancillary legislation, and the relevant procedures in the rapidly expanding body of Convention law.

Further

- As Human Rights comes from an international perspective UK lawyers (and the parties referring the work to the lawyers (!)) will also need to consider not only the convention decisions of national courts of other member states in Europe but also the significant jurisprudence of other jurisdictions around the world with human rights charters or constitutional bill of rights. See for instances the New Zealand Bill of Rights Act 1990 where the courts have adopted a rule of prima facie exclusion of evidence obtained in breach of the Act.
- It is crucial to remember that human rights challenges are usually based on more than one article.
- Furthermore as a “living instrument” it should be given a broad and dynamic interpretation.
- There is no formal doctrine of precedent.
- To take just one Article as an example please see Article 2 (but note Articles 6 and 8 are also extremely important). (See also **R v Secretary of State ex parte Alconbury Developments** Times Law Reports 10 May 2001.

Article 2 – Right to Life

1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is:
 - (a) in defence of any person from unlawful violence;
 - (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
 - (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

An offshore disaster such as Piper Alpha would undoubtedly trigger a challenge under Article 2. Remember “life” includes “physical integrity”. There is a clear obligation on the State to fully investigate deaths.

Although questions of causation will always arise, public authorities such as the Health and Safety Executive, local authorities, health authorities, etc. may be under a duty to protect the public (and their employees) from health risks such as AIDS, BSE, E-coli and from environmental danger and life threatening hazards such as radiation, explosions, asbestos etc. – e.g. Bhopal gas leak, Chernobyl etc. (See **Indian Council for Enviro-Legal Action v Union of India** [1996] 2 LRC 226).

LCB v UK (1998) 27 EHRR 212 – Woman diagnosed with leukaemia following father’s exposure to radiation while serving in RAF at Christmas Island in the 1950s. No breach of Article 2. But in **McGinley v UK** (1999) 27 EHRR 1 where the victims of the testing themselves applied, the court found under Article 8 that they should have been provided sufficient information to enable them to assess the possible consequences.

Guerra v Italy (1998) 26 EHRR 357 – illegal toxic emissions causing arsenic poisoning and possibly cancer. Claim under Article 2. Court awarded £3,000 to the applicants to compensate them for the fact that the authorities had not provided them with sufficient information about a pesticide factory to enable them to assess the risks of living in its vicinity.

See also **McCann v. UK** (1995) 21 EHRR 97 and **Osman v UK** (1999) EHRLR 228.

It is clear in my view that the HRA will have an ever increasing importance in the area of Health and Safety and Corporate Manslaughter (amongst others!) and must be in the forefront of the minds of companies as it stands ready to completely redesign the legal landscape we know.

The same in my view can be said of the legal consequences of human error, especially in relation to the criminal law (see ante). In European law, it looks likely that the “reasonable practicability” test will withstand EU interference. We will know in July/August 2007.

Safety cases must reflect these factors to be of any use at all in the defence of alleged breaches of legislation. British and global industry has much to learn and it must realise its faults and get on with the rebuilding before it is too late! The prosecutions wait in the wings!

**Gerard Forlin LL.B(Hons),
LL.M. (LSE), M.Phil(Cambridge),
Diploma in Air and Space Law,
2-3 Gray’s Inn Square, London WC1R 5JH
Tel: 020 7421 1848/ 020 7242 4986
Mobile: 07947 136349
Fax: 020 7405 1166
e-mail:gerard@gerardforlin.com
www.gerardforlin.com
June 2007**