SIMON JONES MEMORIAL CAMPAIGN

Response to *Corporate Manslaughter: The Government's Draft Bill for Reform*

Anne Jones
on behalf of the Simon Jones Memorial Campaign
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action@simonjones.org.uk
www.simonjones.org.uk

Foreword

This response has been prepared on behalf of the Simon Jones Memorial Campaign. Simon was a 24 year old Sussex University student. He was spending a year out before taking his final exams. To support himself in this period he signed on at an employment agency. On 24th April 1998, regardless of his total lack of experience or training as a stevedore, the agency sent him to Euromin Ltd at Shoreham to help unload a ship. Within two hours of his arrival he had been killed. The Simon Jones Memorial Campaign was set up to get justice for Simon and to get better protection from negligent employers for others like him. After 3 years Euromin Ltd was prosecuted for Corporate Manslaughter. Notwithstanding compelling evidence of negligence, the company was found not guilty. A better drafted law could have made this a guilty verdict.

Corporate Manslaughter – the Government's Draft Bill for Reform

We welcome the fact that this long awaited Bill has finally appeared. There are some very good points in it: it applies to all corporate bodies and there will no longer be general Crown Immunity. It is a disappointment that non-incorporated bodies such as partnerships are not to be included. It is worrying that some organisations e.g. prisons still escape the effects of this Bill.

In his foreword Charles Clarke says:

"It is important that we get this legislation right: that people are free to go about their work safely and that those organisations that pay scant regard for the health and safety of workers and members of the public are held to account"

We agree with the general sentiment but wish to point out that it is not the organisation that has scant regard – it is the decision makers at the head of the organisation who are guilty of this omission.

Introduction

1. We are told that the Government is strongly committed to protecting workers and the public and enabling justice to be done. However the draft bill does not reflect this and shows little heed to the findings and recommendations of the Work and Pensions select committee of July 2004. e.g. The committee recommended that commitments to legislate made in Revitalising Health and Safety in 2000 should be honoured by a Government Bill in the next session of Parliament and that the Government reconsiders its decision not to legislate on Directors' duties and brings forward proposals for pre- legislative scrutiny in the next session of Parliament. We agree that current law operates too restrictively and fails to deliver an effective sanction.

2. The need to strike the right balance between a more effective offence and legislation that would unnecessarily impose a burden on business is emphasised but there appears to be more consideration for the business than the workers. Therefore the balance is not right.

The Need for Reform

3. The main reason for reform has been public outcry at the lack of accountability when companies and in particular large corporations cause the death of workers or members of the public. It is good that the new offence applies to all corporate bodies, including in certain instances parent or other group companies and that for the first time some Crown Bodies are to be included.

4. We wholeheartedly agree with the need for reform. The identification principle has certainly stood in the way of successful prosecutions in many cases but hand in glove with this has been the failure to specify and clarify any obligations by senior managers/directors to the work force and the general public. This contrasts with very specific duties to safeguard the finances of the organisation. To be of any value reform must recognise that the right to life is a human right, to fail to take all reasonable steps to safeguard it is a crime and while taking risks with money in attempt to maximise profit can be acceptable, it is not acceptable to take risks with other people's lives.

5. The consultation paper acknowledges that since 1992 there have been on average only 3 prosecutions per year. In this same period avoidable work related deaths have averaged some 300 per year. Only 20% of those prosecutions have ended in conviction. This is an outrageous record. Only 1% of crimes were

prosecuted and only 0.2% ended in conviction. The identification principle has not been the only obstacle. The lack of clear health and safety obligations at board level and the failure to provide adequate resources for the HSE and training for the police in this complex area is equally to blame.

6. There has been understandable public concern that the law is not delivering justice. The major disasters have received ample media coverage to fuel this but the deaths of individual workers on sites where numerous subcontractors and agencies are involved have received less coverage but have also been failed by the present system. The new proposals theoretically might enable more prosecutions to take place but we understand that the government's own regulatory impact assessment of the proposed law estimates the annual increase in prosecutions would be as few as 5. This indicates that the proposals are not sufficient to protect potential victims, will not improve access to justice for the bereaved and so would not act as a deterrent. If the figures we have heard are correct, the prosecution rate would only rise from 1% to 2.6%. Even if conviction rate rose to 50% this would still leave us with only 1.3% of avoidable deaths due to management failure leading to a conviction. On the present figures, this would mean 4 convictions per year instead of 3. That would not be a great improvement.

The Offence

7. An organisation would be guilty of corporate manslaughter if the way in which its senior managers managed or organised its activities caused a person's death and was a gross breach of a duty of care the organisation owed them.

Organisations which can be convicted of this offence are
(a) a corporation
(b) a government department or other body listed in the Schedule.

It is clear the government recognises that it is the board of directors or senior management that is responsible for a company's behaviour and hence any acts of negligence yet inexplicably only the company or organisation is to be held to account and not the people responsible for its activities. This would be like prosecuting a company for fraud but not placing any sanctions on the directors who carried out the fraud.

Key elements of the current law are retained: the need for an organisation to owe a duty of care to the victim and the high threshold that conduct must have been grossly negligent.

Senior Manager

A person is a "senior manager" if he plays a significant role in –
(a) The making of decisions about how the whole or a substantial part of an organisation's activities are to be organised, or
(b) The actual managing or organising of the whole or a substantial part of those activities.

8. This means there is to be a new test for corporate liability, which focuses on management failure at a senior level within the organisation. This is a far more difficult test to prove than the 1996 Law Commission's suggestion of "serious management failure". The HSE has stated that the majority of work related deaths are avoidable and are the result of management failure. This failure within the organisation is not simply at one level. It pervades the whole organisation. It could be argued that as senior management have the power to insist that systems are run safely e.g. they **can** insist on adequate staffing, proper training and equipment, correct supervision and co-ordination, sufficient rest breaks or adjustment of working hours to avoid fatigue etc. that they are responsible for any general management failure. But statutory duties requiring such action are only placed on "the employer" i.e. the organisation. By specifying that the failure must be at a senior level without clarifying the duties at a senior level or even defining exactly what "a senior level" is could make it impossible to convict this offence. The abuses of the present system remain, where senior management delegate responsibility down the line and so avoid accountability by themselves or their organisation.

9. Where there are management failings throughout an organisation it may be as difficult to associate them with senior management as it is at present to identify a controlling mind. By specifying senior management rather than management failings throughout the organisation, this law would encourage directors and senior managers to delegate management decisions to more junior officers in the organisation so

distancing themselves from the responsibility. More junior management often has to make decisions without the spending power that would enable them to organise the systems more safely. e.g. They might need to take on more staff, acquire better equipment or safety clothing, take on better qualified staff who require higher wages or install better systems of communication. If it can be shown that senior management have failed to supply the funding needed to allow safe systems of work to be organised and maintained, or if they have had a policy of constantly contracting out to companies without checking that their subcontractors are using safe systems of work, then they should be held accountable under this law.

10. We feel that defining a senior manager as someone who has a role in making management decisions about the whole or a substantial part of the organisation is too narrow. It should include all decision makers with the power to "hire and fire", to award contracts for work to be done and who have the authority to decide how money is allocated to ensure systems of work are safe. It must be recognised that if there is a general lax attitude to the welfare of the workers and the safety of the public that this is a systemic failing and the whole organisation should be held accountable. The law should be encouraging a "hands on" approach to safety management from the top down. The narrowness of this definition would allow senior management to distance themselves from responsibility.

11. What amounts to a substantial part of an organisation's activities is defined in such a way that very serious management failure by senior management at any one site or in any one branch of the organisation would escape the scope of this bill simply because there was not proven management failure by management at national or international level. This is setting the bar too high and makes accountability under this law as unattainable as under previous legislation requiring the identification of a controlling mind. It is essential that hand in hand with this legislation there is a statutory requirement for directors and senior management to ensure that their organisation is complying with all requirements under HSWA and MHSWR. In this way failings resulting in death can be associated with the organisation as a whole and the bill then just might have some deterrent effect.

12. The proposed offence will not apply to individual directors or others. This is a retrograde step as it is impossible to divorce the behaviour of an organisation from the behaviour of the decision makers at its head who decide its actions and control its behaviour. It is also contrary to the promises stated in Revitalising Health and Safety 2000. Of itself the organisation cannot behave badly but there can be a general climate of negligence brought about by senior management prioritising profits/output/efficiency at the expense of the safety of the work force or members of the public.

13. The Law Commission's 1996 report included a proposal that a director or senior manager could be prosecuted for assisting or conniving at an offence of corporate killing. The new draft bill specifically leaves this out and thus weakens the legislation and removes any deterrent effect it might have.

14. The Government's consultation paper of 2000 expressed concern that without punitive sanctions against company officers, there would be insufficient deterrent force to the new proposals and it proposed that there be an additional offence of contributing to a management failing that caused death. As the views from respondents were "evenly split", we find it inexplicable that the Government now is

"clear that the need for reform arises from the law operating in a restricted way for holding organisations to account…. and this is a matter of corporate not individual liability. We do not intend to pursue new sanctions for individuals or to provide secondary liability."

By this we understand that the Government has ignored the views of 50% of respondents and in its desire to protect the potential offenders from prosecution has decided to omit the one reform, which would have had a real deterrent effect and protected the potential victims.

Gross Breach

(1) The breach in the duty of care is regarded as "gross" if the failure in question constitutes conduct falling far below what can be reasonably accepted in the circumstances.

(2) In deciding that question the jury must consider whether the evidence shows that the organisation was failing to comply with any relevant health and safety legislation or guidance, and if so –

(a) how serious was the failure to comply;

(b) whether or not senior managers of the organisation (i) knew or ought to have known, that the organisation was failing to comply with that legislation or guidance (ii) were aware, or ought to have been aware, of the risk of death or serious harm posed by the failure to comply (iii) sought to cause the organisation to profit from that failure.

15. We agree that the offence should not target organisations that are making every effort as far as is reasonably practicable to conduct their operation in a safe and proper manner yet by the oversight or ineptitude of a junior member of staff, a death has occurred. Therefore we support the test for a gross breach as "falling far below what could reasonably be expected".

16. We are concerned that in the effort to clarify situations, which would meet this criterion, that an additional test has been introduced i.e. whether or not the organisation sought to profit from the breach. This is problematical because not all organisations covered by the bill are profit making and it fails to consider those organisations that simply do not care. The suggestion in 1996 by the Law Commission that the proposed offences should be reckless killing, killing by gross carelessness and corporate killing would have enabled this to be taken into account. The deaths would have been caused by gross carelessness. Indeed many of the cases that have reached public notice indicate that the main problem is a lack of care for the welfare of others rather than a direct profit motive. e.g. In the sinking of the Herald of Free Enterprise, it is unlikely that the company or any one within it, sought to profit directly by leaving the bow doors open but they failed to consider the possible consequences of such activity and failed to act to prevent it. This is no less culpable than driving at 60 miles per hour in a 30 limit and involuntarily killing someone. The failure to consider the safety of others and to modify behaviour appropriately is the crux of the problem. The grossly careless behaviour does not directly benefit the individual or the organisation. Nevertheless it is criminal and should be treated as such.

17. While compliance or failure to comply with Health and Safety Law and Guidance are reasonable criteria to consider, we feel that other standards should also be considered e.g. Compliance with the manufacturer's safety instructions, British Standards, Construction Industry Training Board Standards, accepted industry best practise etc. according to what is relevant in a particular case.

18. It might be more appropriate to indicate at what level negligence is regarded as gross or criminal. e.g. Serious management failure might be defined as grossly negligent if neglect of one or more Health and Safety regulations had led to death. However it is accepted that, as in the current position, whether conduct was simply negligent or grossly negligent is for the jury to decide.

Relevant Duty of Care

(1) A "relevant duty of care", in relation to an organisation, means a duty owed under the law of negligence by the organisation –

(a) to its employees
(b) in its capacity as occupier of land, or
(c) in connection with (i) the supply by the organisation of goods or services (whether for consideration or not), or (ii) the carrying on by the organisation of any other activity on a commercial basis, otherwise than in the exercise of an exclusively public function.

19. When considering a duty of care to the victim although the draft bill spells out the types of activities involved we feel there is still a loophole that allows agencies/contractors supplying workers to another employer to escape accountability. Many agencies are effectively subcontractors who simply provide labour. Few of them are aware of or take responsibility for their health and safety obligations (HSE research 2000). This consultation refers to risk management but as many agencies do no risk assessment of the work to which they send their labourers, even failing to visit the premises of the host employer to check if safe systems of work are in operation, it is obvious they are failing in their duty of care. However when such a worker is killed at the site of the host employer, as a general rule only the host employer is investigated and considered for prosecution.

20. I have sat in the Old Bailey and heard a host employer's legal representative state that as the agency worker was not directly employed by the host employer responsible for his death that the host employer owed him no duty of care! This area needs clarifying particularly in our present climate of a "flexible" workforce, where not only are many workers in the most hazardous of jobs (construction and dock work) supplied by agencies but agencies often supply their workers to other agencies so that it can be very

difficult to establish exactly who is the employer. In this case as in many others, the agency was not even investigated.

21. We agree entirely that the offence needs to be clear on the circumstances in which an organisation has an obligation to act. Clarity here would simplify compliance with the law and would also simplify proving the case following infringement of the law. It is also important that any definition be as comprehensive as possible in an effort to prevent clever argument by defence counsel allowing an offending organisation to escape justice.

22. We accept that as an alternative to a criminal investigation there may be other ways of investigating the omissions by public bodies. We do not accept e.g. that public inquiries are sufficient to hold the Government to account because the Government has to approve the public inquiry and has power to decide its terms of reference. This is a bit like the Government policing itself. Accountability to ministers, judicial review and other methods of accountability should complement the offence of corporate manslaughter not the other way round. The court of law we hope is truly independent of the Government. Moreover, if the Government fails to allocate funds appropriately and in sufficient quantity to ensure compliance of Health and Safety Law and taxpayers are killed as a result of this, then we as taxpayers have the right to hold the government to account for its failure to provide adequate protection. In this instance, the Government should be as answerable to the taxpayer as a company has to be to its shareholders. If the Government persistently underfunds a body that has responsibility for enforcing safety law, then the Government is negligent.

Remedial Orders

23. The proposed sanction would be an unlimited fine. Such a fine is already available under HSWA yet rarely following a death is the fine imposed anywhere near large enough to have a punitive or deterrent effect. There is also the problem of ensuring payment of fines. Judges seem unwilling to impose a fine of sufficient magnitude – say 10% of annual turnover. Companies are very adept at presenting their accounts so as to appear poorer than they are and some companies simply go into liquidation to avoid paying the fine and then set up elsewhere under another name. The assets of a company under investigation would need to be frozen to prevent this last evasion.

24. Greater deterrence would be effected if an organisation found guilty of corporate manslaughter had to cease operating until all of the failings that led to the death had been rectified and an acceptable plan of action introduced to prevent future deaths. For very large corporations only the branch that caused the death would need to be sanctioned in this way but the financial loss incurred would punish the whole group.

25. Remedial orders would also be a better way of punishing Crown Bodies but the problem would be less complicated and hopefully would never arise if individual decision makers were held liable for the managerial failings. It is wonderful how personal responsibility focuses the mind.

26. We agree that a time limit should be set for taking remedial action but feel the fine for failure to comply is set too low. It may be the Home Secretary's desire to relieve business of its "burdens" that is responsible for the commendable proposal - that courts can order an organisation that has been convicted of corporate manslaughter to take specified steps to remedy the breach in care which led to the death - being made worthless by the proposed maximum fine being set at £20,000 for failure to remedy the problem.

27. One of the many factors leading to Simon's death was a failure to employ sufficient staff and in particular a supervisor. As the annual pay of a supervisor is likely to be more than a one off maximum fine, it is unlikely that a company in this position would take remedial action. When we consider the costs of rectifying problems on the railways to prevent further disasters, it is obvious that this fine would have no deterrent effect whatever. Any fine must be suitably large to ensure that the organisation will avoid incurring it or failure to comply should result in a seizure of an organisation's assets.

28. Permitting the organisation to be granted serial extensions on the time allowed could lead to perpetual procrastination and the failings would never be put right. Preventing an organisation from operating and so making money during the remedial process would encourage it to expedite the remedial course of action.

Application to Crown Bodies

29. The main reason for reform has been public outcry at the lack of accountability when companies and particular large corporations cause the death of workers or members of the public. It is good that the new offence applies to all corporate bodies, including in certain instances parent or other group companies and that for the first time some Crown Bodies are to be included. We agree that Crown bodies should not receive blanket immunity. This is an outmoded concept with little to justify it.

30. We have some reservations however on those Crown Bodies and other organisations that are to be exempt from the law. In particular it is possible, that exempting the Crown from this offence when it or a private company acting on its behalf in the care of prisoners is responsible for a death, may be in breach of Articles 2 and 14 of the Human Rights Act. It is difficult to see how an inquest or public inquiry could be sufficient. These investigations do not apportion blame and do not impose any sanctions. Therefore they are not an adequate means of redress.

31. The excuses put forward in paragraph 20 of the consultation for excluding Government bodies from the offence of corporate manslaughter bears a remarkable similarity to the arguments put forward by the directors of large corporations to distance themselves from the offence. e.g. If the Government procures services from a contractor that has a known track record for causing fatalities of members of the public and its workforce, it is culpable because it should have chosen a contractor with a good safety record and should have included the requirement to operate safe systems of work as part of the contract. In short the Government is failing to accept responsibility for the chain of events reaching down from its decisions. Perhaps if the Government were to be held accountable it might be more circumspect with how it discharges its duties and dispenses our taxes with benefit to us all.

32. We are particularly concerned that functions relating to the custody of prisoners should be exempt from this act. Prisoners are particularly vulnerable members of society. There have been a number of high profile cases where negligence by the prison service, companies running private prisons and the police have resulted in the untimely death of prisoners. The worry is that there are many more similar cases, which fail to reach the public notice. We can only stress in the strongest terms that those with responsibility for the care of people in custody should be held accountable under this legislation.

33. It is not good enough to rely on inquests because these are conducted by coroners who are for the most part untrained for the job. Some are doctors, who might be able to direct an inquest into a death from possible medical negligence, but when it comes to a death in custody, we need someone trained in law to analyse what duties were owed to the prisoner and to establish whether these duties were appropriately discharged.

The inquest should be retained and in future be carried out by coroners who have specialised in this area of law. This should be complementary to holding prison services and police to account under this law if the evidence indicates that management failings resulted in the death.

Unincorporated Bodies

34. The offence does not apply to unincorporated bodies. While we appreciate that the structure of certain unincorporated bodies would make it difficult to prosecute them, we feel it would be better to have the law cover all employing organisations and to have a separate schedule of those types of organisation which are exempt.
We feel it is disingenuous to argue:

"extending the law to unincorporated bodies is not a question of reforming the current law, where it already applies… It raises a question of whether the law should be extended to apply to a new range of organisations."

Applying the law to Crown Bodies is already doing this; why should unincorporated bodies be treated differently?

35. We note that the draft bill excludes the police forces from those bodies that come within the range of the bill. Although a desire to include them at a later date is expressed we feel it is worrying that they are not

included from the outset. There have been recent high profile cases of deaths in police custody and police exceeding their powers with regard to policing peaceful demonstrations. If coralling peaceful demonstrators and members of the public who were simply going about their lawful business and denying them access to food, water, shelter or toilet facilities results in the death of one or more of those people, then the police force responsible for this action should be held to account. It is also possible that denying people such basic human rights could result in a separate charge under ECHR.

Causation

36. We have little problem with the Government's position on causation. It is reasonable that corporate liability should not ensue where an individual has intervened in the chain of events in an extraordinary fashion causing death, or the death was otherwise caused by an extraordinary or unforeseeable event.

Extent and territorial application

37. The offence applies only to England and Wales. In common law manslaughter an individual can be prosecuted for a death which occurred abroad. We fail to see why employing organisations should be treated more leniently than individuals. While it might be difficult to prosecute in some circumstances we feel that if a senior management failure in England caused a death in say Northern Ireland or Germany, then the organisation should be prosecuted because the crime took place in England.

Investigation and Prosecution

38. We are pleased to see that the new offence is to be investigated by the police but that the expertise of the HSE will also be used. It is good that the Protocol for Liaison has been further developed and that the CPS will be the prosecuting authority as it is for all laws of homicide. ecause of the complexity of the investigation for this offence and the lack of experience by police forces in its investigation, we would request that the Home Office would introduce specific specialist training for police to allow them to conduct investigations more effectively. This lack of training combined with the sparseness of previous cases for reference makes it more difficult to prepare an effective prosecution case.

Private Prosecutions

39. We do not agree that removing the requirement to obtain the consent of the Director of Public Prosecutions to bring proceedings for the new offence would lead to spurious, insufficiently well-founded prosecutions being brought, which would ultimately fail. Once more it is the interests of the potential offender that are put to the fore – not those of the victims and the bereaved families.
It should be noted that there is already an unfair financial and emotional burden placed on the bereaved relatives. They have often lost their breadwinner. Where a single young person is the victim the family have huge financial burdens associated with the death and inquest for which no help is available and no financial compensation is payable by the company in these instances.

40. The financial hurdles alone are so great that only in exceptional cases could a private prosecution be considered. There is therefore virtually no chance of an insufficiently well-founded private prosecution. For this reason alone it is unreasonable to add the additional obstacle of requiring the consent of the Director of Public Prosecutions.

Summary

41. We reiterate that we are pleased that a draft bill has finally been produced but feel that as it stands it will not protect workers or members of the public from being killed as a result of work related activity. We do not feel it places sufficient responsibilities on organisations and the decision makers who control the activities of those organisations. As it stands it would be difficult to convict any organisation of the proposed offence and the penalties need to be more innovative and effective to provide an adequate deterrent.

Anne Jones on behalf of Simon Jones Memorial Campaign
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