

THE CENTRE

FOR

CORPORATE ACCOUNTABILITY

RESPONSE TO THE CONSULTATION

DOCUMENT OF THE

***DEPARTMENT OF ENVIRONMENT,
TRANSPORT, AND THE REGIONS***

"REVITALISING HEALTH AND SAFETY"

September 1999

SUMMARY¹

- New legal Duties should be imposed upon directors
- Companies should be legally obliged to provide safety information in their annual reports
- If the DETR is serious about “encourag[ing] unscrupulous employees to take their health and safety responsibilities seriously” [Para 54] it must provide the HSE sufficient resources so that it can carry out the:
 - investigation of all major injuries;
 - in relation to major injuries and deaths, the prosecution of those companies and their senior officers where sufficient evidence exists.
- The HSE must at the same time, re-orientate its whole enforcement and prosecution policy setting aside much of the “philosophy” set out in the 1972 Robens report which currently grounds its work. The Robens report argued that the criminal law should have a “limited role”. However, its conclusions were both empirically and analytically flawed. Crucially, the Robens report failed to distinguish those incidents;
 - which result in major injury and death and where a serious criminal offence may have taken place (although action must also, of course, be taken to ensure that it doesn’t happen again), from
 - those breaches of the law that do not result in any harm (only an increased risk of harm) where a wholly preventative approach – as laid out in Robens - is required.
- The HSE must ensure that it has a “consistent” investigation and prosecution policy
- The HSE must change its prosecution policy in line with the Environment Agency
- The HSE must consider the application of GBH offences and extend its protocol of liaison with the police in relation to major injuries
- the HSE must change its practice in relation to the investigation and prosecution of directors and managers for health and safety offences
- HSE inspectors should not prosecute any cases involving death or major injury. The HSE should instruct lawyers
- Lawyers representing the HSE should be instructed by the HSE, in cases involving death and major injury, make strong representations to the magistrate that the case be heard in the Crown Court.
- the government should enact a number of new result based offences and an offence relating to reckless endangerment

¹ This response focuses on two areas covered in the Consultation Document.(i) Action by Employers – Paragraphs 44 and 45 (ii) Action by Health and Safety Regulators – Paragraphs 51-56

- The Government should consider a system of “proportionate” and “equity” fines.

DIRECTORS DUTIES

1. Paragraph 44 of the Consultation document states that, “The message is clear. Better health and safety performance, through effective risk assessment, can deliver better business performance, while health and safety failures can damage companies’ reputation and profits. If businesses put health and safety on their board agenda, ideally as a standing item, and make it a responsibility of a named board director, they could do much to raise awareness across the organisation and make a real difference in performance.”
2. This is a rather elliptical way of raising the issue of the “responsibilities” of company directors. In our view, one of the key loopholes in current law is the absence of safety duties upon directors. The law places duties upon “employers” – which usually takes the form of “companies” – not on directors. This has two effects.
 - the absence of duties promotes poor safety performance
 - It allows company directors to evade prosecution – simply because they did not have a “duty” to do something.

What are the Duties of Company Directors

3. Lord Parker, in the 1970 case of *Huckerby v Elliot*, clearly sets out the lack of obligations imposed upon directors in relation to safety.

"I know of no authority for the proposition that it is the duty of a director to, as it were, supervise his co-directors or to acquaint himself with all the details of the running of the company. Indeed it has been said [in another case] that amongst other things it is perfectly proper for a director to leave matters to another director or to an official of the company, and that he is under no obligation to test the accuracy of anything that he is told by such a person or even to make certain that he is complying with the law."¹

This position is in stark contrast to the multitude of financial duties imposed directly upon directors – some of which can result in seven years imprisonment if breached - as set out in company legislation.

The Case for Duties: (i) Prevention

4. In the opinion of the Health and Safety Executive (HSE), good safety management requires directors to take on board proper safety obligations. Simply to avoid corporate activities causing death and injury is important, in the HSE's view, that directors have clear and explicit obligations.
5. This is articulated in guidance published by the HSE for companies which wish to comply with "good practice". The guidance implies a very different regime of directors' duties than those laid down by the law. The HSE's publication, "Successful Health and Safety management", states that:

"Organisations that are good at managing health and safety create an effective framework to maximise the contribution of individuals and groups. Health and safety objectives are regarded in the same way as other business objectives. They become part of the culture and this is recognised explicitly by making health and safety a line management responsibility. The approach has to start *at the top*. Visible and active support, strong leadership and *commitment of senior managers and directors are fundamental* to the success of health and

safety management. Senior managers and *directors are fundamental* to the success of health and safety management. Senior managers communicate the beliefs which underlie the policy through their individual behaviour and management practice. *Health and safety is a boardroom issue and a board member takes direct responsibility for the co-ordination of effort.*"² (Italics added)

6. In addition, with regard to a company's legal obligation to write statements of health and safety policy, the guidance states:

"Written statements of health and safety policy should at the very least:

- set the direction for the organisation by;
 - *demonstrating senior management commitment;
 - * setting health and safety in context with other business objectives;
 - * making a commitment to continuous improvement in health and safety performance;
- Outline the details of the policy framework, showing how implementation will take place by *identifying the Director or key senior manager with overall responsibility for formulating the implementing policy*
- having the document *signed and dated by the Director or Chief Executive*" (italics added)

7. The CBI has also advised companies that its safety policy should include in their safety policies: "The Board is responsible for providing resources for health and safety and welfare" and "I am the member of the Board responsible for Health and Safety."³

9. The British Standards Institute has taken the same approach. In its *Guide to Occupational Health and Safety Management Systems*.⁴ It states even more explicitly that:

"Ultimate responsibility for occupational health and safety rests with top management. Here best practice is to allocate to a person at the most senior management level (e.g. in a large organisation, a board or executive committee member) with particular responsibility for ensuring that the OH&S management system is properly implemented and performing to requirement in all locations and spheres of operation within the organisation... Senior management should demonstrate by example their commitment by being actively involved in the continual improvement of occupational health and safety performance."

10. It is clear that in the view of the HSE, BSI and the CBI that the prevention of death and injury in the workplace requires directors taking upon themselves safety responsibilities. Because these duties are not enshrined in law, the HSE can at present, only cajole and encourage company directors to take on these obligations. Some companies do and some don't. It is surely now time for these obligations to be given a legal basis.

The Case for Duties: (ii) Accountability

11. The absence of duties assists directors escaping conviction for either an offence under section 37 of the Health and Safety at Work Act 1974 (as noted above), or, following an injury or death, for an offence under traditional criminal law like manslaughter or causing grievous bodily harm.
12. **Health and Safety Offences:** The HSE can prosecute directors and senior company officers, through section 37 of the Health and Safety At work Act 1974. This states that:

"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 person who was purporting to act in any such capacity, he as well as the body corporate shall be guilty of that offence . "

13. First, the HSE must prove that the *company* committed an offence by breaching a duty imposed by the 1974 Act itself. Secondly, it must show either (i) that the director “consented” or “connived” in the offence, or (ii) show that the corporate offence resulted from “any neglect” on his or her part.
14. Lack of directors duties facilitates company directors to escape prosecution under section 37 for ‘neglect’. This is because, in order to prove “neglect”, it is first necessary to show that the director had a particular “duty” which was breached. Prosecution for “neglect” therefore depends on whether the company itself has imposed duties upon the director – through its safety policy or terms of employment, which depends on the individual company. The absence of duties therefore allows directors the opportunity to avoid prosecution for “neglect” simply by ensuring that their companies - which they control – do not impose safety duties upon them! This is entirely unsatisfactory.
15. The absence of duties also indirectly impinges upon attempts by prosecutors to prove “consent” and “connivance” in section 37. Although neither of these require proof of duty - a director *consents* to the commission of an offence when he is "well aware of what is going on and agrees to it" and *connives* when "he is equally well aware of what is going on but his agreement is tacit, not actively encouraging what happens but letting it continue and saying nothing about it.."5 – it would be much easier to discover cases of consent and connivance, if duties were placed upon directors.
16. It is difficult to disentangle this legal loophole on the one hand and the HSE’s lax prosecution policy on the others (see paras. 23-58), but what is clear, probably as a result of a combination of the two, the HSE prosecutes only a very small number of managers and directors under section 37.
 - Only 1% of all prosecutions taken by the HSE are against a manager or director,

	TOTAL PROSECUTED	OFFENCES SECTION 37 PROSECUTIONS	% OF PROSECUTIONS WHICH ARE SECTION 37
1992/3	2157	34	1.6%
1993/4	1793	13	0.7%
1994/5	1803	13	0.7%
1995/6	1767	21	1.2%
1996/7	1490	27	1.8%
1997/8	1654	6	0.4%
1998/9	1797	11	0.6%
TOTAL	12461	125	1.0%

17. **Manslaughter:** Only two directors have been prosecuted in relation to workplace deaths. Since 1992, the HSE have only referred 24 deaths – 1% of the total – to the Crown Prosecution in relation to possible culpability of a director or senior manager.

HSE Manslaughter Referrals

YEAR	NOS OF DEATHS	TOTAL OF REFERRALS	NOS TOTAL REFERRALS TO COMPANIES	NOS OF REFERRALS RELATING TO COMPANIES
1992/3	339	7	3	
1993/4	296	5	2	
1994/5	272	12	3	
1995/6	258	8	4	
1996/7	287	12	6	
1997/8	274	19	5	
1998/9	257	21	1	
TOTAL	1983	84	24	

18. There are a number of reasons for this low figure discussed below at paras 53-58. But one contributing factor is the absence of safety duties. Prosecutors often complain about the difficulty of pinpointing criminal culpability on directors in large companies, because of the complexity of safety responsibilities. This problem could be substantially avoided by imposing clear safety duties upon directors. Prosecutors would first be able to find out whether directors fulfilled their duties, and if satisfied, then they would be able to look further down the chain of responsibility within the organisation.

There needs to be a change in the law so that company directors have clear cut safety duties.

Annual Reports

19. Paragraph 45 states that “publishing details of health and safety performance in companies Annual Report can be another powerful tool. There is already a requirement to report environmental performance. Whether on a compulsory or voluntary basis a higher profile for health and safety in annual reporting could help improve performance.”
20. In the early/mid 1990’s, many groups proposed that companies should be forced to publish details of any legal actions that have followed breaches of health, safety and environmental law. The campaign for Freedom of Information (CFI) published a Bill - the draft Corporate Safety and Environmental Information Bill - which would, if enacted, have compelled companies (employing⁶ more than 50 people) to publish in the director's report, information on:
- notices or orders served by the authorities enforcing regulatory law.
 - any convictions of the company, a director or one of its officers, in relation to any common law or regulatory offence.
 - compensation payments in consequence of injury
21. It was argued⁷ that these changes were required to ensure:
- shareholder's rights: "Shareholders, who are best placed to influence and change a company's policy, have no legal right to be informed of the company's safety and environmental record."
 - management awareness: Publication "would concentrate the minds of the board of directors on environmental and safety issues."
22. Schedule 7 of the companies Act and section 79 of the 1974 Health and Safety at Work Act does empower the Secretary of State for Trade and Industry to make regulations obliging companies to

set out information on health and safety in their annual report. No regulations have been made. Research on annual reports indicate that companies choose to provide very little information on their safety record.⁸

The Campaign for Freedom of Information’s proposal that companies should be legally obliged to publish information on convictions should be enacted by this government.

The Health and Safety Executive

23. DETR report, paragraph 51 states in part: “some people argue that more regulatory effort should be directed at punishment through investigation, enforcement action and prosecution particularly whether lives have been put at risk. These activities use a lot of resources and more effort put towards them would be at the expense of preventative action.”
24. In our opinion, this is a highly inadequate analysis of HSE’s current “enforcement policies”. The DETR appears not to recognise the implications of HSE’s policies which leads to thousands of companies and hundreds of directors escaping prosecution for crimes involving serious injury and death. This high level of corporate impunity:
 - brings into question the integrity of the criminal justice system built upon principles of due process and equality before the law;
 - fails to respond to the needs of families and victims – considered legitimate in relation to other offences - for moral justice and accountability.
 - fails to establish a system of deterrence in which companies are deterred from placing the lives of workers at risk
25. Issues of criminal justice and accountability in relation to workplace death and major injury should not be “balanced” against other work of the HSE – a process inferred by Paragraph 15. These principles are far too important to be simply sacrificed to ensure that HSE’s system of preventative is not effective. The contrary is also the case. It is simply not good enough for the HSE to conduct “several projects to assess the best possible balance between various regulatory measures.” A whole change of emphasis is required which has clear resource implications.

The Law

26. In relation to workplace safety, there are two types of offences that may be committed by companies and their senior officers.
 - a health and safety offence, or
 - a conventional offence of violence, like manslaughter, or inflicting grievous bodily harm. These offences can only apply after a major injury or death.
27. A word needs to be said about conventional offences of violence. These are offences which require evidence that:
 - the defendant’s conduct caused a death or injury and;
 - the conduct in question was done either “intentionally” as in the offences of *murder* or *causing GBH*⁹ “recklessly” as in the offence of *Inflicting GBH*¹⁰ and *Administering a Poisonous Substance*¹¹ or gross negligence as in the offence of *manslaughter*

28. The HSE does acknowledge the potential application of manslaughter to workplace deaths. But it still fails to recognise that offences requiring evidence of “intention” or “recklessness” could apply. Yet, in our opinion, it is well within clearly understood notions of how decisions are made within companies to realise that company directors or managers will, in certain circumstances, establish policies or make decisions knowing full well that it would be “practically certain” that as a result someone will suffer death or injury – the legal definition of intention..
29. For example, a director could decide against buying specialist safety equipment having been told (or having being made aware through a history of incidents), that this equipment is essential to prevent workers suffering injury. If a death or injury took place in such circumstances, the state of mind of the director would be sufficient to ground a prosecution for murder or section 18 of the OAPA 1861. It is also not difficult to imagine situations in which directors are fully aware that their conduct carries with it risks of injury to worker – the definition of recklessness - when they make particular decisions. Recklessness is easier to prove than intention: to prove recklessness, it is necessary to show that the defendant actually foresaw that some bodily harm might result from the conduct in question.¹²

MAJOR INJURY

30. The HSE does not publish statistics on its enforcement decisions relating to workplace death and injury. This indicates how little significance it gives to actions it takes in relation to major injury and death over its more general activities. The figures below have not been published before.

Investigation

31. Between 1996-98, there were **47,803** workplace major injuries.¹³
- Only **11.2%** resulted in an HSE investigation.
Even large percentages of the particularly serious categories of the Major Injuries were subjected to low rates of investigation.
 - only **40%** of amputations resulted in an HSE investigation.
In addition there were wide variations in investigation rates, depending on the industry of the injured worker, and the area in the country where the injury took place
 - **25.2%** of major injuries in agriculture were investigated, compared with **5.4%** of those in the extraction and utility supply industries.
 - **13.4%** of major injuries in Yorkshire and North East were investigated compared with **7.2%** in London and South East. Yorkshire and North East also investigated almost double the actual number of major injuries – 987 injuries compared to 519.

Reported and Investigated Major Injuries (1996 to 1998) to Workers by Industry

96-8	INJURIES REPORTED	INJURIES INVESTIGATED	% OF INJURIES INVESTIGATED
AGRICULTURE	1501	378	25.2%
MANUFACTURING	16842	2735	16.2%
CONSTRUCTION	8724	1184	13.6%
EXTRACTION	10146	545	5.4%
SERVICE	10590	523	4.9%
TOTAL	47803	5365	11.2%

Reported and Investigated Major Injuries (1996 to 1998) to Workers by HSE Region

96-8	INJURIES REPORTED	INJURIES INVESTIGATED	% OF INJURIES INVESTIGATED
YORKSHIRE	7371	987	13.4%
WALES+WEST	7902	1035	13.1%
SCOTLAND	5042	626	12.4%
HOME COUNTIES	6690	747	11.2%
MIDLANDS	7341	798	10.9%
NORTH WEST	6239	653	10.5%
LONDON AND SOUTH	7217	519	7.2%

32. **Impunity:** Every major injury could be the result of a serious crime – either a breach of health and safety law or a GBH offence within the Offences against the Person Act 1861. HSE’s low investigation rate provides those (uninvestigated) companies and their senior officers who may have acted either negligently or recklessly with automatic immunity from prosecution.
33. The prosecution rate for health and safety offences after major injury (10.4%) is discussed (and criticised) below. However, one point needs to be made here. There is no reason to believe that, had the HSE actually investigated the 42,438 injuries which remain uninvestigated, the prosecution rate in relation to these injuries would be any different. Therefore, at the very least, assuming HSE’s low prosecution rate, around **4413 companies** have escaped prosecution for health and safety offences involving a major injury, simply because of the low investigation rate.
34. **Lack of Deterrence:** Apart from issues of moral justice and accountability in relation to each *individual* case, the low investigation rate into the vast majority of the most serious of injuries conflicts with any strategy of deterrence. Companies know that they can cause the most serious injuries with the highest degree of recklessness, and in most cases remain immune any form of criminal inquiry.
35. **Lack of Consistency:** One of HSE’s five “principles of enforcement” is “consistency”.¹⁴ The huge disparities in investigation rates in one part of the country from another and in one industry from another appears to be in clear breach of this principle. The HSE states in its policy that “Duty holders managing similar risks expect consistency from enforcing authorities”. It is also the case that *workers* expect consistent investigation responses to any injuries they may suffer. Inconsistency in enforcement was probably the key criticism levelled at HSE by the National Audit Office back in 1994. It stated that “the variation [of investigation rates] between some Area Offices could be seen to be inequitable by employers, and may result in significant risks to employees and the public not being investigated.”¹⁵
36. **Bad Record compared to the Police:** HSE’s infrequent responses to major injury reports should be compared to the police response to the reports it receives of serious injury. The Metropolitan police, for example, categorises certain reports as “incidents requiring immediate response”. This definition includes any reports of “serious injury to people”. The police responds to all of them.

Not only that; the police also has a local target time of 12 minutes for responding to such incidents, and in the last two years succeeded in achieving this target in over 88% of cases.¹⁶ South Yorkshire and Durham police authorities also includes reports of an “injury” as a trigger for an “immediate response”. In addition, 15 further police authorities include “road traffic incidents that result in an injury/serious injury” as “incidents requiring immediate response.” These police forces respond to over 80% of all of these reports within 20 minutes¹⁷

37. The major injuries reported to the HSE are just as likely to be the result of criminal conduct as the “injuries” - particularly road traffic ones – which are defined by the police as “requiring immediate response”. Yet the HSE does not even respond to 88% of those major injuries reported to it – and that is before one considers the time it takes the HSE to respond to those injuries it does investigate. It would be considered intolerable if the police failed to investigate 88% of serious injuries on the road. The same level of criticism that would be attached to the police in such a situation, should be focused on the HSE.
38. **Question of Resources:** The HSE argues that it does not have the resources to investigate more major injuries without seriously jeopardising its other work. It is certainly true that with limited resources it must strike a balance between such reactive work and preventative inspections. However the Executive does not even acknowledge the critical importance of investigating more major injuries; it consistently and explicitly fails to place major injury investigations into a criminal justice context. Jenny Bacon made this point explicitly in an interview when she stated: “I think there's a straight conflict here between the demands of ... the criminal justice system in which people want their accident investigated because they want ... retribution; and with what's needed under health and safety laws (which are what we are responsible for) and which are mainly concerned with protection as opposed to prosecution and punishment. ... But we cannot put the resources into following up accidents primarily to seek retribution ... when what we're supposed to be doing is preventing accidents and protecting workers.”¹⁸ As a result, the HSE does not seek further funding for this purpose and remains complacent about the investigation rate.
39. **Unreported Injuries:** The investigation rate does not take into account the actual number of workplace major injuries. Surveys indicate that the number of reported injuries to the HSE represents only 40% of the total suffered so that the real number of injuries between 1996-8 is over 100,000 and the real rate of investigation about 5%.
40. An unreported injury is just as likely to be the result of corporate criminal conduct as one that is reported. When an injury remains unreported, it does not even have a chance of being investigated and total immunity is provided to the reckless or negligent company. Therefore increasing the number of reported injuries is just as crucial as ensuring a higher investigation rate. At the moment, the HSE relies on employers reporting the injury to the HSE. Employers – particularly those who know they are to blame for the injury – have a vested interest against reporting the injury. Other ways need to be devised to ensure that the major injuries are reported. Examples could be:
 - encouraging victims, their lawyers, advice bureaux etc. to report injuries;
 - establishing systems of reporting with doctors, hospitals and insurance companies

The HSE must:

- establish a system to both (i) investigate and (ii) investigate rigorously, all major injuries reported to it;
- ensure that there is a consistent investigation rate between regions and industries

The DETR

- Must ensure that more resources are provided to the HSE so that the HSE can, like most police forces, investigate all major injuries reported to it.
- Work with the HSE to establish new ways of ensuring that a far higher % of major injuries are reported to it

Prosecution: Health and Safety Offences

41. The prosecution figures below are not entirely consistent with the investigation data since they include a small number of prosecutions resulting from investigations into injuries to members of the public (excluded from the above data.) The *actual* numbers and percentages will therefore be slightly lower.

- Only 10.4% of injuries that were investigated resulted in a prosecution.

Prosecution rates significantly varied depending on where the injury took place.

- The prosecution rate in Scotland (6.4%) was less than half the rate in the Home Counties (13.3%).

In addition, although we have at present no conclusive statistical proof it appears that **none** of the prosecutions were against a company director, manager or other senior officer under S. 37.

Major Injuries in 1996 to 1998, which have resulted in a Prosecution

96-8	MAJOR INJURIES REPORTED	MAJOR INJURIES INVESTIGATED	NUMBER RESULTING IN PROSECUTION	PROSECUTIONS AS % OF INJURIES INVESTIGATED
HOME COUNTIES	6690	747 (11.2%)	99	13.3%
LONDON AND SE	7217	519 (7.2%)	69	13.1%
NORTH WEST	6239	653 (10.5%)	80	12.3%
WALES&WEST	7902	1035 (13.1%)	124	12.0%
MIDLANDS	7341	798 (10.9%)	68	8.5%
YORKSHIRE	7371	987 (13.4%)	78	7.9%
SCOTLAND	5042	626 (12.4%)	40	6.4%
TOTAL	47802	5365	558	10.4%

42. **Low Prosecution Rate:** 10.4% is a very low prosecution rate. There has been no independent or HSE research considering what level of major injuries is the result of failures on the part of companies etc. to comply with health and safety law. The only available research relates to workplace deaths. The HSE did a series of studies in the late 1980s which indicated that about 70% of workplace deaths were the result of “management failure”. In addition, a study in the West Midlands area concluded that 75% of workplace deaths there should have resulted in at least a health and safety prosecution. There is no reason to believe that the cause of workplace major injuries should be any different from this. Obviously, the fact that a death or injury was the result of “management failure” – a term used in the HSE report - does not necessarily imply that there is sufficient evidence to prosecute the company. However, HSE’s reports clearly indicate a majority should result in prosecution. In total, therefore, in our view, at least 40% of all major injuries should result in prosecution.
43. As a result therefore, we can conclude that the HSE failed to prosecute (in relation to the injuries investigated) at least **1588** companies. It would of course be many more if the HSE increased its investigation rate. Just as with its low investigation rate, HSE’s low prosecution rate seriously impacts upon issues of moral justice, accountability and deterrence.
44. **Breaching its own Enforcement policy:** It appears that the HSE is failing to prosecute companies in relation to major injuries despite sufficient evidence. The HSE’s own enforcement policy states that prosecution will be considered when there is, *inter alia*, “judged to have been potential for considerable harm arising from breach”
45. The policy also states that the decision to prosecute “must also take account of the criteria set down in the Code of Crown Prosecutors, and in Scotland by the Procurator Fiscal.” The English/Welsh Code states that there are two stages in the decision to prosecute. First, the “evidential test”, and if this is passed the “public interest test”. In relation to the public interest test, the Code states that “in cases of *any seriousness*, a prosecution will *usually take place* unless there are public interest factors tending against prosecution which *clearly outweigh* those tending in favour” (italics added).
46. The 10% prosecution rate in relation to major injury appears to be in breach of HSE’s own policy and the Code of Crown Prosecutors. The second limb of HSE’s policy – “potential for considerable harm arising from breach” – will have definitely existed in that “considerable harm” has in fact been caused, and so whenever sufficient evidence of a breach has been discovered, prosecution should take place. And in relation to the Code of Crown Prosecutors, it is difficult to see what public interest arguments could be made out for not prosecuting whenever the evidence test is satisfied – a test probably satisfied in at least 40% of the cases.
47. **HSE’s Cautioning Policy:** If the HSE are only prosecuting in 10% of cases, what are inspectors doing when they decide not to prosecute, even though evidence exists? It must be assumed that they are either providing oral/written advice or imposing an improvement or prohibition notice. Effectively, they are “cautioning” the company (though police cautioning does require an admission of guilt). Home Office guidelines on cautioning, indicate that the “nature and extent of the harm or loss resulting from the offence” should be taken into account before cautioning. Yet the HSE - not officially covered by these guidelines – are issuing “cautions” despite very serious injuries.

The HSE must:

• **change its written prosecution policy so that it states explicitly that it will prosecute after every death and major injury where sufficient evidence exists. This would bring it in line with the policy of the Environment Agency which states that: “where there is sufficient evidence, the Agency will normally prosecute ...[after] any ... incidents or breaches which have significant consequences of the environment ...”.**

Prosecution: Grievous Bodily Harm Offences

48. The HSE does not consider the possible application of GBH offences. This is crucial since they are the “gate-keeper” preventing the police from investigating these incidents. The Executive’s position on GBH offences is totally different from its stance on workplace deaths and manslaughter. Why is it that the HSE and the police do not work together to consider the possible commission of crimes under the Offences against the Person Act 1861? The HSE has said very little in public on this subject, but it appears that the HSE does not think that the offences in the Act apply to the standard workplace major injury situation. HSE’s position, however, does not stand legal scrutiny.¹⁹
49. Apparently, there appears to be two reasons why the HSE does not think section 20 (for an example, though the same basic argument applies to section 18) applies to a workplace injury, but that manslaughter might to a death. The first, is the legal requirement that it must be shown that a director or manager was “aware of the risk” of injury – i.e. the requirement for recklessness.
50. Whilst it is of course true that the required mental state in section 20 is a stricter test than the one required for manslaughter, it certainly does not preclude the possibility of prosecution. In many cases directors are fully aware of the risks inherent in their decisions; the problem is that the HSE simply does not conduct investigations with a view to determining what the awareness of directors or managers was or wasn’t. In addition, there is a general bias within the HSE against considering that directors and managers might act “recklessly”. They may be ignorant or incompetent to a very high level, but, in the HSE’s view, they certainly do not act “knowingly”.
51. HSE’s second reason appears to be that except in the most extraordinary situations (which would anyway, as a matter of course, be investigated by the police i.e. injury through “foul play”) workplace major injuries are not the result of “wounding” or “inflicting”. This is because, even if an injury is *caused* by a director or manager, it is not the result of a “direct application of force”. However, HSE’s understanding of the word “inflict” is not correct. There is no requirement for a “direct” or indeed “indirect” application of force. This has been made very clear by the case of *Burstow*²⁰ where the House of Lords held that the word “inflict” in section 20 was interchangeable with the word, “cause”. The judge held that it “is not a necessary ingredient of the word “inflict” that whatever causes the harm must be applied directly to the victim. It may be applied indirectly, so long as the result is that the harm is caused by what had been done.”

The HSE must extend the “protocol of liaison” with the police so that it includes the possible commission of GBH offences contained in the Offences against the Person Act 1861

DEATHS

Prosecution: Health and Safety Offences

52. Every workplace death is subjected to an HSE investigation; the issue of major concern is HSE's prosecution policies.
- **18.8%**²¹ of deaths in 1996-8 resulted in a prosecution for health and safety offences. All of the prosecutions that did take place were against companies: none were against directors or managers.
 - There was a big differential between one region and another. **23%** of deaths in the Midlands resulted in a prosecution compared to **13%** in Scotland.
 - **72%** of these prosecution took place in the magistrates court (where the maximum fine available is £20,000). In the North West all nine of its prosecution took place in the magistrates court.
 - The average fine per death was **£18,032**. It ranged from an average of **£36,237** in Wales and the West to **£5,196** in the Midlands.

Table of deaths to workers (employees, self-employed, work-experience, trainees) taking place between April 1996 to April 1998 which resulted in a prosecution

	NOS OF DEATHS	NOS OF PROSECS FOLLOWING DEATHS	% OF DEATHS RESULTING IN A PROSEC.	NUMBER OF PROSECS RESULTING IN CONVICTIONS	NUMBER OF CASES IN MAG COURTS	% OF CASES IN MAG COURTS	AVERAGE FINE PER CONVICTION
MIDLANDS	62	14	22.6%	12	12	85.7%	£ 5,196
HOME COUNTIES	72	15	20.8%	14	9	60.0%	£ 26,179
LONDON	72	15	20.8%	14	12	80.0%	£ 10,250
WALES/WEST	102	20	19.6%	19	14	70.0%	£ 36,237
YORKS	72	13	18.1%	13	8	61.5%	£ 11,792
NW	52	9	17.3%	9	9	100.0%	£ 9,000
SCOTLAND	78	10	12.8%	10	8		£ 14,575
TOTAL	510	96	18.8%	91	72	75.0%	£ 18,032

53. **Immunity:** The prosecution of companies for only 19% of deaths is an extraordinary low figure considering all the evidence that indicates that the majority of deaths result from management failure. In addition there can be no justification for the HSE's failure to prosecute under section 37, any director or manager in relation to these deaths. In the late 1980's (as noted above) the HSE published a series of reports indicating that 70% of deaths resulted from "management failure". In addition, an independent investigation into 24 workplace deaths in the West Midlands between 1988-1992 indicated that 75% of deaths should result in *at least* a health and safety prosecution.²²
54. **Breach of HSE's Policy:** As discussed in relation to major injuries, the failure to prosecute – when evidence is available - is clearly in breach of HSE's own prosecution policy and the Code of Crown Prosecutors. It also breaches HSE's "principles of enforcement" that requires "consistency".

The HSE must change its prosecution policy and practice in relation to deaths so that (i) whenever sufficient evidence exist and (ii) assuming manslaughter has been ruled out, a company and senior company officer, should be prosecuted for a health and safety offence.

Prosecution: Manslaughter

55. In the last ten years – and after over 3000 workplace deaths – only two deaths have resulted in a conviction of a company or senior company officer for manslaughter. This conviction level must be compared to two independent studies which researched the level of corporate culpability for workplace deaths.
- In 1994, the West Midlands Health and Safety Advice Centre reinvestigated 24 deaths that took place in the region between 1988 and 1992. On the basis of the evidence, Anthony Scrivener QC stated that four of the deaths should have resulted in a manslaughter prosecution against a director. If this was reflected nation-wide, last years deaths alone should have resulted in 45 corporate manslaughter prosecutions.
 - This research is supported by new research, to be published at the end of the year by Gary Slapper, Open University Professor of Law. He found that 20% of the 28 deaths he looked at in detail should have been referred to the Crown Prosecution Service for consideration of corporate manslaughter.
56. **HSE's Referral Mechanism:** In 1993, the HSE instituted a policy where inspectors were supposed to refer deaths to the Crown Prosecution Service where they believed there was a prima facie manslaughter case. This has resulted in the referral so far of 84 workplace deaths – though only 24 of these referrals related to potential evidence against a senior company officer (that could, in legal terms, be said to represent the company.) This is 1.2% of the total. See Paragraph 17 above
57. The HSE argues that the low referral rate indicates a low level of corporate culpability on the part of senior company officers. However, in our opinion it is more likely to do with a failure of the part of the HSE to investigate the conduct of senior company officers. Our opinion is supported by the West Midlands report which indicated a series of highly inadequate investigations into workplace deaths. The HSE also argues that its conclusions about the level of corporate culpability is justified by the very few prosecutions carried out by the Crown Prosecution Service. Again, in our opinion, the lack of prosecutions does not support low rates of culpability. First, the CPS relies on cases referred to it by the HSE – which are not necessarily the strongest cases. Secondly, the CPS often fails to ensure that further investigation is carried out into these deaths. Thirdly, the CPS appears to take a very conservative view on managerial culpability as indicated by the recent High Court decision to give leave to the family of Simon Jones over the CPS decision not to prosecute for manslaughter.

58. **The New Protocol:** In April 1998, the HSE instituted a new policy. This new protocol gives the police a formal investigative role; from now on every workplace death is supposed to be attended by a police detective of supervisory rank who will make an initial assessment about whether "the circumstances might justify a charge of manslaughter." No statistics are available to assess this policy. However in our opinion, the police need to carry out a parallel enquiry to the HSE, not just make an "initial assessment" as the protocol requires. How can a police officer make a proper assessment of whether a company director has acted with gross negligence without actually conducting an investigation? As Detective Chief Superintendent Bill Hacking, an ACPO representative states, "[i]t is only after a major investigation by the police, and possibly other agencies that an apparent act of negligence or recklessness is identified. Past experience has also shown that in the early stages of an investigation the full facts are not always revealed". If this is the case why then does the protocol not require more than an "initial assesment"?

Prosecution of Directors and Managers

59. In the HSE's Annual Report of 1992, the HSE's Director General stated that. "The Executive has ... made clear our intention, which I again emphasise, to prosecute the directors of companies, particularly in cases where their failure to ensure proper conditions has led to injury." As set out in the table above (Para. 16) between 1992 and 1999, the HSE prosecuted a total of 12,461 offences. Yet, despite HSE's rhetoric, almost all of the charges were laid against companies rather than company officers. Throughout this period, it only prosecuted 125 directors or managers - less than 1% of the total prosecutions. In 1997/8 itself it in fact prosecuted twice as many workers as directors/mangers – 6 directors compared to 12 workers.
60. In 1998, HSE published an "enforcement policy statement", which placed even further emphasis on HSE's intention to prosecute directors. It stated that "enforcing authorities should identify and prosecute or recommend prosecution of individuals, including company directors and managers, if they consider that a conviction is warranted and can be secured." Since then it has prosecuted only 11 directors – which though double the number prosecuted a year earlier, was a third of the number prosecuted in 1992.
61. The HSE inspectors - through burden of work, resources and training - do not try and discover evidence against directors and managers. Inspectors are content with a prosecution against the company at the very most. As a result directors and managers escape untouched, however negligent or reckless they may have been. Though it is true that the absence of directors duties (discussed above) can be an obstacle to a successful prosecution, this can in no way excuse the lack of prosecutions.
62. The importance of bringing directors to account through the criminal court is too often overlooked. Apart from it being important that directors should not be seen to above the law and escape criminal accountability, the backbone of any system of deterrence, in relation to preventing corporate harm, must be action against those in control of the company. As Braithwaite and Geis have stated,

"white collar criminals are among the most deterrable types of offenders because they satisfy two conditions. They do not have a commitment to a crime as a way of life, and their offences are instrumental rather than expressive. Corporate crimes are almost never crimes of passion; they are not spontaneous or emotional, but calculated risks taken by rational actors. As such they should be more amenable to control by policies based on the utilitarian

assumption of the deterrence doctrine .. Individual corporate criminals are also more deterrable because they have more of those valued possessions that can be lost through a criminal conviction, such as social status, respectability, money, a job and a comfortable home and family life."^{23,24}

The HSE must put its rhetoric into practice and prosecute directors and managers under section 37 of the HASAW Act.

Sentencing

63. The DETR seems to be putting great faith in the case of *Howe* The table above (Para. 52)) shows that a company is on an average fined £18,032 for a death. Apart from the Home Counties and in Wales & West, the average fine in every HSE Region was in fact **below £15,000**. The profits of those companies sentenced is not known; but the fines are likely to be low both in absolute terms and relative to their profits.²⁵ One of the reasons for the low fines imposed upon companies – even when a death has taken place - is directly related to HSE’s failure to ensure that more cases are heard in the Crown court which have the power to impose unlimited fines. Compare for example, the average fine in the North West (£9,000) where all the cases were heard in the Magistrates Court to the fines imposed in the Home counties (£26,000) where 40% took place in the Crown Court..
64. The recent guidance given in the case of *R v Howe* will mean that successful cases taken in the higher courts are likely to result in higher fines. Yet this ruling will have absolutely no impact unless sentencing for death/injury cases takes place in the Crown Court. The decisions about referral are made by the Magistrates themselves – but HSE inspectors, prosecuting the case, can make submissions that either trial (if pleading not guilty) or sentencing (if guilty plea) can take place in the Crown Court. The HSE has consistently told this committee that they have little control over the question of which court cases are heard – this is not the case.²⁶ In our opinion (though no research has actually every been done into this question) the low Crown Court prosecution/sentencing rate is directly the result of HSE inspectors failing to argue their case persuasively to the magistrates courts. It is not clear whether this is due to lack of HSE policy or legal inexperience or incompetence of HSE inspectors who are not trained in court procedure and who have little experience of “mode of trial hearings”.

HSE inspectors should not prosecute cases involving death or injury. Environment Agency inspectors do not prosecute their cases, nor do most if not all, Local Authority inspectors. HSE inspectors do not have the legal experience to prosecute these cases and it should be the job of professional lawyers. In particular lawyers should do the “mode of trial hearings”.

The HSE should also institute a policy stating that HSE inspectors (or, lawyers acting on their behalf) should try to persuade magistrates that all death (and most major injury) cases should be heard and sentenced in the Crown Court.

65. Paragraph 54 of the DETR report states that “The Government is considering whether to make imprisonment available the courts for all health and safety offences and whether the maximum fine for breaches on summary conviction should be increased from the present level of £20,000 for offences under the 1974 Act”.

In our opinion, it has always been an anomaly that imprisonment has not existed as a possible sentence for the majority of health and safety offences, when it exists in other regulatory statutes. Any change in the law, will, however, only make a difference if the HSE prosecute more directors and managers.

Although we support an increase in the maximum level of fines that can be imposed in the magistrates courts, we think more sentencing decisions should be made in the Crown Court where unlimited fines are available. In addition, the government should consider a system of “proportionate” fining so that fines relate to both the gravity of the offence and the profits of a company, as well as a system of “equity fines” that can be imposed upon the shares of a PLC. Disaster Action is publishing detailed proposals on both these subjects next month.

New Offences

66. One issue that was not mentioned in the DETR report was the need for result based offences. At the moment a company is prosecuted for the same offence whether no injury, major injury or a death took place. This needs to be changed. There needs to be a series of result based offences – one involving major injury and another involving death.. It is wrong that a company which has caused a death should be prosecuted for the same offence as a company that has simply breached the law but caused no harm.

67. The HSE argues it would be unfair to have result-based offences since the death or serious injury that takes place is "fortuitous" - a purely "chance" event: "Health and safety offences stem from the potential for harm - it is often a matter of chance whether injury, or even death, follows an accident."²⁷ In other words, that it would be unfair for one negligent company to be prosecuted for a more serious offence than another negligent company if, one day, the negligence of the first company happens, by some "unlucky" event to cause a death. This is a peculiar argument since if this were valid, it should apply to all result-based offences in the general criminal law - like murder, manslaughter or causing GBH As Sir John Smith states, the criminal process is full of cases where,

"a person's liability to conviction turns entirely on events which do not affect his danger to society or his moral blame worthiness or innocence, but on events which were outside his control - matters, so far as he is concerned, of chance."²⁸

68. There ought to be one other new offence – that of reckless endangerment. Companies that “recklessly endanger” a person’s life should be prosecuted for a separate offence (that clearly identifies the level of culpability) than simply an offence of “failing to comply with a duty” y.

There should be a change in the law to create a series of result based offences and an offence of reckless endangerment.

HSE and The Robens Philosophy²⁹

69. The HSE itself states that its “view of enforcement derives from the philosophy set out in Lord Roben’s report “Safety and Health at Work”. However the Roben’s report’s conclusion on the ”role of the criminal law” is flawed on two basic points:

- its empirical foundations are inaccurate;

- it failed to distinguish between incidents that resulted in serious harm from those which increased the risk of harm, but where harm had not yet resulted.

70. **“Criminal Law not Applicable”**: Robens main argument against the use of the criminal law was that the manner in which "accidents" take place does not allow for the application of the "traditional concepts of the criminal law". The report stated: "Our deliberations over the course of two years have left us in no doubt that the most important single reason for accidents at work is apathy. The fact is - and we believe this to be widely recognised - that the traditional concepts of the criminal law are not readily applicable to the majority of infringements Relatively few offences are clear cut, few arise from reckless indifference to the possibility of causing injury, few can be laid without qualification at the door of particular individuals. The typical infringement or combination of infringement arises rather through carelessness, oversight or lack of knowledge or means, inadequate supervision or sheer inefficiency." ³⁰
71. The legitimacy of this conclusion can only be determined by empirical analysis: The Robens committee used very few studies to justify its conclusion on the causes of "accidents". It stated that: "Some four fifths of all accidents reported in recent years under the Factory Acts are said to arise from such apparently simple causes as *handling materials, falling objects and the misuse of hand tools*. These are sometimes referred to as common accidents. We are told that few of these accidents - perhaps one in six - involve a breach of a specific regulation. In a survey of construction sites in 1966, a team of factory inspectors kept 140 sites under surveillance for six months. Of the 270 reportable accidents that happened during the survey, only 50 (19%) could be regarded as due to clear breaches of regulation."(italics added)
72. It is difficult to see why these studies support these conclusions. The finding that *only* one sixth of the accidents resulted from a "breach of a regulation" could simply be a reflection of the narrow definitions of the Factory Act Regulations. Given this narrowness, a company or its senior officers could well have been grossly negligent or reckless, without actually being in breach of a regulation. The Robens report also seems to imply that because only 15% of "accidents" (i.e. 1 in 6) resulted from a breach of regulation, the criminal law should have a limited role. But if 15% of deaths or injuries on the road were considered to be a breach of road law, this would not stop the need to prosecute drivers.
73. Furthermore, the fact that most of the "accidents" were caused by "handling materials, falling objects and the misuse of hand tools", should not imply that a director (or at least a company) lacked criminal responsibility. If a director does not provide appropriate protective clothing, a worker will suffer injury through "handling materials" or if the company has failed to provide proper training and supervision, a worker could die through the "misuse of hand tools". If the director were aware of the risks or should have been aware of the risks, serious criminal charges could be laid.

74. The committee's conclusion also did not take into sufficient consideration other evidence available to it at the time. Without comment, the Robens report discounted and rejected evidence pointing to a different conclusion. For example W. H. Thomson, a senior solicitor at the time, stated that: "I am consulted every year by about 10,000 persons injured at work and by the relatives of persons killed. ... And time and time again, I find that the employers were plainly negligent and that the accident could and should have been prevented but they failed to take reasonable care. ... I am not suggesting that employers should be prosecuted for minor errors of judgement any more than motorists are today. ... the cases I am concerned about are the cases where the employers have plainly been guilty of gross persistent inexcusable negligence. There are in my experience a large number of cases."
75. The Robens Committee never cited this evidence, referring only to the study mentioned above involving 270 "reportable", accidents many of which might have been very minor. The Robens Committee also totally ignored a study which the committee itself commissioned from the National Institute of Industrial Psychology. This stated that: "nearly all accidents are the inevitable result of unsafe working systems which could themselves be made safe by employers, by a combination of hazard analysis, planning, training and supervision".³¹
76. In 1972, therefore, the evidence available did not support the Roben's thesis. And nothing has changed since. Studies as noted above now suggest that a majority of workplace deaths and injuries are due to corporate negligence, with a significant minority being the result of gross negligence or recklessness on the part of a senior manager or director.
77. **Criminal law "an irrelevancy"?:** A second line of argument used in the Robens report stated that the criminal law was, in any case, not helpful in ensuring that companies were prevented from breaching health and safety law. It argued that when a legal breach had been discovered, "the process of prosecution and punishment by the criminal courts is largely an irrelevancy. The real need is for a constructive means of ensuring that practical improvements are made and preventative measures adopted. Whatever the value of the threat of prosecution, that actual process of prosecution makes little direct contribution towards the end. On the contrary, the laborious work of preparing prosecutions .. consumes much valuable time which inspectorates are naturally reluctant to devote to such little purpose."³²
78. When an inspector investigates a "near miss" or discovers dangerous conditions, Robens is correct to say the most important task is to ensure that the situation does not recur. When poor standards are discovered, the priority must be to ensure that conditions are improved so that injury or death do not take place. Prosecution may seem inappropriate when the company is willing to make the necessary changes; it would serve little purpose, particularly if the risk of danger was not great and the company was, in the main, safe.

79. In addition, the absence of "harm" removes one of the key ingredients in assessing whether particular conduct is judged to be "real" crime and worthy of a response from the criminal justice system. Though, the absence of harm does not preclude a response from the criminal justice system, the occurrence of harm is usually the key trigger, and without it no action is usually taken. However, the Roben's strategy is not appropriate when death or injury has occurred. Though the incident could certainly be entirely unforeseen and accidental, it might well be the result of an offence of manslaughter, assault or causing GBH. Whilst, obviously, the authorities must deploy measures to ensure there is no recurrence, issues of justice and accountability should now come to the fore. It is appropriate that the death or major injury should be treated like any other incident that might be the result of violent crime. This requires rigorous investigation of both the company and its senior officers, followed by a decision to prosecute if there is sufficient evidence. Without this response, it is not possible to filter those companies and directors who have committed serious crimes. Simply put, Roben's arguments that the criminal law is not a useful technique in the prevention of death and injury does not apply when injury or death has actually occurred.

¹ Elliott [1970] 1 All ER189 at p.194

² p.9

³ "Developing a Safety Culture" p.18-21

⁴ BS8800,

⁵ See *Huckerby V*

⁶ In an earlier version it was 10. A draft "Corporate Accountability Bill" drafted in 1991 by company solicitors Davies Arnold Cooper included this provision (section 8) so that it applied to all companies.

⁷ Citizen Action Compensation Campaign, "Disclosure of Safety and Environmental Information Bill Briefing" (1990)

⁸ See "Corporate Responsibility: Health and Safety in company Annual Reports", Disaster Action, April 1997

⁹ Section 18 of the Offences against the Person Act 1861: "Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person with intent to do some grievous bodily harm to any person ... shall be liable ... [to a maximum penalty of life imprisonment]

¹⁰ Section 20 of the OAPA 1861, "Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of [an offence] ... and shall be liable ... [to a maximum penalty of 5 years' imprisonment]"

¹¹ Section 23 + 24 of the OPAPA, "Whosoever shall unlawfully and maliciously administer to, or cause to be administered to or taken by any other person any poison, or other destructive or noxious thing so as thereby to endanger the life or such a person, or so as thereby to inflict upon such person any grievous bodily harm, shall be guilty of an offence, and being convicted thereof shall be liable to imprisonment for any term not exceeding ten years."

¹² See *Mowatt* 3 ALL ER 47 and *Savage and Parmenter* [1991] 4 All ER 698. See Smith and Hogan(1998) Criminal Law p. 441-2 for summary.

¹³ The figures below relate to injuries to workers. This includes employees, self-employed, work experience and trainees. It excludes injuries to members of the public

¹⁴ See HSE's Enforcement Policy Statement.

¹⁵ National Audit Office, "Enforcing Health and Safety Legislation In the Workplace" HMSO, (!994)

¹⁶ See Report of the Commissioner of Police of the Metropolis (1997/8), P. 109/110

¹⁷ See Audit commission, 97/98 Performance Indicators, Police and fire services p.38-40, and P9-10

¹⁸ Interview with Jenny Bacon, Health and Safety Bulletin, Jan 1998

¹⁹ See, New Law Journal, "Corporate GBH" October 1999, (forthcoming)

²⁰ 1998 1 Cr. App. R. 177

²¹ These figures are based upon comparing HSE's Event Investigation numbers to prosecutions. In a very few cases, an EIN will relate to more than one death – which are not taken into account in our figures.. The actual figures may therefore be a little higher – but not by much at all.

²² See "The Perfect Crime? How companies can get away with manslaughter", West Midlands Health and Safety Advice Centre (1994)

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²⁴ J Braithwaite and G Geis, "Theory and Action for Corporate Crime Control", Crime and Delinquency, April 82, 292, at p302

²⁵ See The Perfect Crime? P.96 on the level of fines compared to the wealth of the companies.

²⁷ See Parkes, B "One for All and All for One: Reforming Manslaughter Law" Health and Safety Bulletin,

²⁸ "The Element of Chance in Criminal Liability", [1971] Crim.L.R p63

²⁹ See Bergman, D. "Straw Philosophy and Defective Legislation", Health and Safety at Work Magazine, October 1999, forthcoming

³⁰ Dept of Employment, Safety and Health at Work, Report of the Committee 1970-72, p.82, para 261

³¹ Quoted in A.D. Woolf, *Robens Report - the Wrong Approach* (1973) Industrial Law Journal, 2, 88 at p.90.

³² Dept of Employment *ibid.*, Para 261, p82