THE CENTRE

FOR

CORPORATE ACCOUNTABILITY

EVIDENCE TO THE ENVIRONMENT SUB-COMMITTEE

Environment, Transport and Regional Affairs Select Committee

"THE HEALTH AND SAFETY EXECUTIVE"

Sept.1999

Tel:	**(0207) 490 4494**
e-mail:	info@corporateaccountability.org
Address:	**Fourth Floor,197/199 City Road, London EC1V 1JN**
Web Page	**www.corporateaccountability.org**

EVIDENCE TO THE ENVIRONMENT SUB-COMMITTEE OF THE SELECT COMMITTEE ON ENVIRONMENT TRANSPORT AND THE REGIONS

SUMMARY

The HSE's "enforcement" philosophy, policy and practice is highly inadequate and leads to thousands of companies and directors escaping prosecution for crimes involving serious injury and death.. This high level of corporate impunity has a number of very serious implications.

- it brings into question the integrity of the criminal justice system built upon principles of due process and equality before the law;
- it fails to respond to the needs of families and victims – considered legitimate in relation to other offences - for moral justice and accountability;
- it fails to establish a system of deterrence in which companies are deterred from placing the lives of workers at risk.

HSE's policies are grounded in the flawed conclusions of the Robens Report which has allowed the HSE, consistently and explicitly, to place its work outside a criminal justice context.

Our strongest criticisms are directed at the HSE's **failure** (between 1996-8)

- to ensure that more than 60% of major injuries are reported to the HSE
- to investigate more than 11.2% of major injuries to workers;
- to prosecute more than 11.4% of major injuries and 18.8% of deaths;
- to prosecute a single director or manager after any workplace death or major injury;
- to prosecute more than 28% of death cases in the Crown courts;
- to consider the possible commission of GBH offences after a major injury;
- to have a consistent investigation/prosecution policy between regions/industries;
- to refer more than 1.2% of deaths to the police where they consider the possible commission of corporate manslaughter to the police;

The HSE needs to separate organisationally its preventative inspection work from its injury/death investigations. It needs to have a different enforcement philosophy for each – one which emphasises the importance of criminal justice concerns to its investigation of major injuries/deaths. The HSE's criminal justice work needs to have a large financial imput to stop the current high level of corporate immunity

THE CENTRE FOR CORPORATE ACCOUNTABILITY

The Centre for Corporate Accountability is a new organisation, which through research, advocacy and advice aims to increase the accountability of companies and their senior officers whose negligent, reckless or intentional conduct causes harm. The Centre undertakes research into how the criminal justice system deals with corporate harm and advocates changes to law and practice where necessary. The Centre's Management Committee and Advisory Council includes most of Britain's leading lawyers, academics and "activists" working in this area.[1] It is the only organisation in the country to have systematically analysed HSE's enforcement and criminal justice activities.

This evidence only summarises our concerns. We would like to be given the opportunity to provide oral evidence to expand our arguments as well as to suggest a series of necessary reforms to the operation of the HSE.

INTRODUCTION

1. This year is the 25th anniversary of the Health and Safety at Work Act 1974 which established the Health and Safety Commission (and its Executive) as the body with primary responsibility for the "regulation" of occupational health and safety in Britain. It is therefore an appropriate moment that this Committee takes a long and hard look at the operation of the Health and Safety Executive.

2. This evidence is solely concerned with the adequacy of the HSE's "enforcement" activities – which comprises over 50% of HSE's time and budget.[2] The HSE uses the term, "enforcement activities" to encompass the Executive's system of workplace inspection, its investigations of workplace death and injury, and, in particular, the decisions taken by its inspectors, when breaches of the law are discovered, about what administrative or legal action should be taken.

THE LAW

3. It is important to clarify the law. 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.

4. **Health and Safety Offences:** The 1974 Act imposes duties upon "employers" – which are usually companies - to ensure "so far as is reasonably practicable" the health and safety of its employees and others who may be affected by its operations. The key criminal offence in the Act is proved by showing a failure on the part of the company to comply with these duties – which includes the obligation, for example, to provide proper training, instruction, equipment and a safe system of work.In effect, this offence is a crime of negligence – based around the concept of 'reasonableness' - without the usual obligation to show that the breach of duty caused some harm. A company is prosecuted for the same offence whether or not death, major injury or no injury took place.

5. A director or senior company officer can also be prosecuted for a health and safety offence – though this can only happen in an indirect manner. First the HSE must prove that the company committed an offence. Then the HSE must show that this corporate offence resulted from his "consent" or "connivance" or was "attributable to any neglect" on his part.

6. **Conventional Crimes 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* [3] "recklessly" as in the offence of *Inflicting GBH* [4] and *Administering a Poisonous Substance*[5] or gross negligence as in the offence of *manslaughter*

7. As we shall see 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.

8. 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.[6]

MAJOR INJURY

9. 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.

10. Workplace injuries reported to the Health and Safety Executive are divided into two categories.
    • Over-Three day Injuries – preventing a person from working for more than three consecutive days
    • Major Injuries – these are more serious injuries, and include amputations, electrical burns leading to unconsciousness and exposure to biological agents. They are all sufficiently serious to be categorised as "grievous bodily harms".[7]

Investigation

11. Between 1996-98, there were **47,803** workplace major injuries.[8]
    • 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%

12. **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.

13. 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.

14. **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.

15 **Lack of Consistency**: One of HSE's five "principles of enforcement" is "consistency".[9] 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."[10]

16. **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.[11] 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 minutes.[12]

17. 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.

18. **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."[13] As a result, the HSE does not seek further funding for this purpose and remains complacent about the investigation rate.

19. **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%.

20. 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

Prosecution: Health and Safety Offences

21. 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%

22. **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 between 1998-1992 concluded that 75% of workplace deaths should have resulted in at least a health and safety prosecution[14]. 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.

23. 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.

24. **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".

25. 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).

26. 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.

27. **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.

Prosecution: Grievous Bodily Harm Offences

28. 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. [15]

29. 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.

30. 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".

31. 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* [16] 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."

DEATHS

Prosecution: Health and Safety Offences

32. Every workplace death is subjected to an HSE investigation; the issue of major concern is HSE's prosecution policies.
    - **18.8%**[17] 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 CONVIC-TION
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

33. **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. [18]

34. **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".

35. **Low Fines**: An average fine of £18,032 per death is very low.. Apart from the Home Counties and in Wales &West, the average fine in every HSE Region is **below £15,000**. The low level is directly linked to the high percentage of cases sentenced in the magistrates courts (see below). The profits of those companies sentenced is not known; but the fines are likely to be low both in absolute and relative to their profits.[19] 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..

36. 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 the 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. 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".

37. HSE inspectors should not prosecute these cases; it should be the job of professional lawyers. In particular lawyers should do the "mode of trial hearings". The HSE should institute a policy stating that HSE inspectors (or, lawyers acting on their behalf) should try to persuade magistrates that all deaths cases should be heard and sentenced in the Crown Court.

Prosecution: Manslaughter

40. 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.

39. **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.

HSE Manslaughter Referrals

YEAR	NOS OF DEATHS	TOTAL NOS OF REFERALS	TOTAL NOS OF REFERALS 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

41. 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.

41. 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 assessment"?

HSE AND THE ROBENS PHILOSOPHY[20]

42. 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 harrm, but where harm had not yet resulted.

43. **"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 coarse 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." [21]

44. 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 mis-use 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).

45. 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.

46. Furthermore, the fact that most of the "accidents" were caused by "handling materials, falling objects and the mis-use 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.

47. 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."

48. 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".[22]

49. 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.

50. **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 beaching 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."[23]

51. 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.

52. 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 unforseen 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] The Management Committee is composed of Louise Christian (solicitor); Alan Dalton (Environment Agency Commissioner); Professor Steve Tombs (John Moores University); Charles Woolfson (University of Glasgow); Deborah Coles, (Co-director, INQUEST): Conor Foley (Amnesty International) The Advisory Council is composed of Upendra Baxi (Professor, University of Warwick); Barrie Berkley (Disaster Action); Chris Clarkson (Professor, University of Leicester); Martyn Day (Partner, Leigh Day Solicitors); Barbara Dinham (Co-Director, Pesticide Trust); Ann Elvin (Relatives Support Group); Colin Ettinger (Irwin Mitchell Solicitors); John Hendy QC (Barrister); Mick Holder (London Hazard Centre); Sadiq Khan (Partner, Christian Fisher); Michael Mansfield Q.C. (Barrister): Richard Meeran (Partner, Leigh Day); Fiona Murie (Officer, Spanish Trade Union, (Departamento Confederal de Salud Laboral); Michael Napier (Partner, Irwin Mitchell Solicitors): Rory O'Neill, (Editor, Workers Health International Newsletter); Professor Phil Scraton (Centre for Studies in Crime and Social Justice); Dr Gary Slapper (Director of Law, Open University); Stephanie Trotter (Co-Gas Safety, Executive Director); Owen Tudor(Health and Safety Officer, Trades Union Congress): Celia Wells (Professor of Law, Cardiff University): Marlene Winfield (National Consumer Council)

[2] See HSE annual report

[3] Section 18 of the Offences against the Person Act (OAPA) 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]

[4] 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"

[5] Section 23 + 24 of the OAPA 1861, "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."

[6] See *Mowattt* 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.

[7] See CPS Charging Standard

[8] 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

[9] See HSE's Enforcement Policy Statement.

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

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

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

[13] Interview with Jenny Bacon, Health and Safety Bulletin, Jan 1998

[14] See “The Perfect Crime? How companies can get away with manslaughter”, West Midlands Health and Safety Advice Centre (1994

[15] See, New Law Journal, “Corporate GBH” October 1999, (forthcoming)

[16] 1998 1 Cr. App. R. 177

[17] 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.

[18] See “The Perfect Crime? How Companies can get away with Manslaughter”, West Midlands Health and Safety Advice Centre (1994)

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

[20] See Bergman, D. “A Game of Chance?”, Health and Safety at Work Magazine, November 1999

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

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

[23] Dept of Employment ibid., Para 261, p82