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The Corporate Manslaughter and Corporate Homicide Act 2007 or the Health and Safety (Offences) Act 2008: Corporate Killing and the Law

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Abstract

This thesis examines the regulatory and legislative approach taken in the United Kingdom to deal with deaths arising from work related activities and, in particular, deaths that can be directly attributed to the behaviour of corporations and other organisations. Workplace health and safety has traditionally been seen in the United Kingdom as a regulatory function which can be traced to the very earliest days of the Industrial Revolution. With an emphasis on preventing workplace accidents and ill-health through guidance, advice and support, the health and safety legislation and enforcement regime which had evolved over the best part of two centuries was considered inadequate to effectively punish corporations considered responsible for deaths caused by their activities following a series of disasters in the late twentieth and early twenty-first centuries.

To address this apparent inadequacy, the Corporate Manslaughter and Corporate Homicide Act 2007 was introduced creating the offence of corporate manslaughter and corporate homicide. Based on a gross breach of a relevant duty of care resulting in the death of a person, the Act effectively changed what had previously considered a matter of regulation, an approach that had obvious weaknesses and shortcomings, to one of crime and criminal law.

Whether this is the best approach to dealing with deaths caused by an organisation is challenged in this thesis and the apparent distinction between ‘criminal’ and ‘regulatory’ offences is also examined. It was found that an amended Health and Safety at Work etc. Act 1974 to include a specific offence of corporate killing, in conjunction with the Health and Safety (Offences) Act 2008 would almost certainly have resulted in a more effective approach to dealing with organisations responsible for causing deaths as consequence of their activities. It was also found that there was no substantive difference between ‘regulatory’ and ‘criminal’ law other than the stigma associated with the latter, and that distinction would almost certainly disappear, at least in the context of worker safety, as a consequence of the penalties available following the introduction of the Health and Safety (Offences) Act 2008.
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Declaration I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature ______________________________

Printed name ______________________________
1.0 Introduction

That law, hitherto half dormant, is awake, and bent upon the command that all these deadly shafts shall no longer mangle or murder, every year, two thousand human creatures but that they shall henceforward be securely fenced.¹

From Sunday the law ensures improved justice for victims of corporate failures. The Act provides that companies and organisations can be found guilty of corporate manslaughter on the basis of gross corporate failures in health and safety.

We are sending out a very powerful deterrent message to those organisations which do not take their health and safety responsibilities seriously. Angela Eagle, Justice Minister²

The Corporate Manslaughter and Corporate Homicide Act 2007 was met with both support and criticism when it was introduced.³ Intended as a response to inadequacies identified in the legal approach to corporate killing, its origins can be traced back to the Law Commission Consultation Paper on Involuntary Manslaughter published in 1994, although the campaign for a change in the law dealing with corporate killing started to gather momentum in the late nineteen-eighties following a series of accidents that resulted in major loss of life.⁴

Whilst the Consultation Paper dealt with most aspects of involuntary manslaughter, one section was devoted to corporate manslaughter and the problems of holding organisations accountable for deaths arising from their

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¹ 'Chips', Deadly Shafts, vol Volume XI (Household Words, 1855)
activities. When the Consultation Document was published, the Law Commission was basing its views on one failed corporate manslaughter prosecution taken against P&O Ferries Ltd following the capsize of the Herald of Free Enterprise in 1987 with the loss of one-hundred and eighty-four lives. The Herald of Free Enterprise was not the first accident with a major loss of life attributed, at least in part, to the behaviour of an organisation and it was certainly not the last in the years leading towards the end of the twentieth and the start of the twenty-first century. The King’s Cross Fire in 1987, Piper Alpha and the Clapham Rail Crash in 1988, the Southall Rail Crash in 1997, the Larkhall gas explosion in 1998 and the Hatfield Rail Crash in 2000 are just a few of the accidents that occurred during this period, each with a significant loss of life and attributed to the activities of large national and international organisations. There were few prosecutions for manslaughter following these accidents which were mainly unsuccessful resulting in some commentators suggesting that corporations were getting away with murder.

The few successful corporate manslaughter prosecutions were in respect of the very smallest companies where the actions of the senior management and the actions of the company were deemed to be one and the same. Discussing the crime of manslaughter, former Home Secretary Jack Straw commented on the ineffectiveness of the then-existing approach to dealing with deaths arising from corporate activities, where the criminal law was unable to secure a conviction against either corporations or individuals “whose acts or failures have contributed to the deaths”.

The accusation of companies getting away with murder was a minority view, but more typically it was thought that large corporations were not being adequately punished for causing deaths as a consequence of their activities. Although large fines were imposed in a few cases, these tended to be the exception rather than the rule and in general fines were low, even where death had occurred as a consequence of the offence. Tombs and Whyte pointed out that what they

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5 The Law Commission, *Law Commission Consultation Paper No 135, Involuntary Manslaughter (LCCP 135)* op. cit. n.4, p.17
6 *R. v P & O European Ferries (Dover) Ltd.* (1990) 93 CrAppR 72 (Central Criminal Court)
described as “safety crimes” did not attract the same level of punishment as other forms of crime including corporate crime, an observation made by many other commentators.⁹ Perhaps more importantly, there was a perception that the stigma normally associated with murder or manslaughter was not attached to these offences, which were viewed as regulatory rather than criminal in nature. In only a very few cases were individuals found liable for manslaughter as a consequence of deaths arising from work activities. The close of the twentieth century and start of the twenty-first saw a demand for something to be done to address this apparent gap in the law; what was to be done was much less clear other than the punishment of corporations for the specific offence of causing death through their activities.

The clamour for something to be done was based on the assumption that the existing law protecting workers and others was in some way inadequate and at least some of this perceived inadequacy could be attributed to the regulatory nature of health and safety legislation intended to protect workers (and others). The origins of health and safety legislation in the United Kingdom can be found in the Factories Act 1802 which, as discussed in more detail in the next Chapter, was generally ineffective although it did establish a regulatory, rather than criminal approach to workplace safety. The nineteenth and twentieth centuries saw a gradual extension of the legislation in both range of workplaces covered and the requirements imposed on employers, culminating in the consolidating Factories Act 1961. The next significant piece of legislation dealing with worker safety was the Health and Safety at Work etc. Act 1974, a major departure from the previous approach to workplace safety in so far as it ended the industry and/or activity specific approach where laws were written for specific types of activity (the Factories Acts, Mines and Quarries Acts, Agriculture Acts, Offices, Shops and Railway Premises Act and so on) and focussed on all work activities. It also moved away from the previous emphasis placed on absolute requirements to a risk-based approach requiring the protection of workers’ safety so far as is reasonably practicable. A very significant development in the 1974 Act was the

inclusion of persons, other than employees, who could be affected by an employer’s activities.

The 1974 Act was generally welcomed when it was introduced but it had two important characteristics that perhaps led to it being considered inadequate for dealing with the major accidents described previously.\(^\text{10}\) It focussed on contraventions rather than outcomes and it was still perceived as a regulatory rather than criminal piece of legislation. This distinction between ‘regulatory’ and ‘criminal’ law, with health and safety legislation falling under the former category, is seen by some commentators as one of the main reasons for organisations not being properly punished when their activities result in loss of life.\(^\text{11}\) The United Kingdom legal system has no formal distinction between regulatory and criminal law; legislation identified as regulatory is subject to exactly the same processes as that considered criminal in nature, so any difference can only be attributed to perception or modes of enforcement and penalties, rather than its intrinsic form or structure.\(^\text{12}\) Why this is significant is as a consequence of the differing responses to a guilty verdict; unlike being found guilty of what would be considered a criminal offence, there is little or no perceived stigma attached to regulatory offences resulting in indifference being demonstrated towards them by individuals and organisations. This response will be discussed in detail in this thesis. Health and safety offences can attract very large fines but unlike a guilty verdict of manslaughter, for example, there is very little stigma attached to them - “the only significant difference in terms of


\(^{11}\) Tombs and Whyte, Safety Crimes op. cit. n.9, p.168; C. Wells, Corporations and Criminal Responsibility (Oxford Monographs on Criminal Law and Justice, 2nd edn, Oxford University Press 1993) 25

\(^{12}\) The 1707 Act of Union maintained the independence of the Scottish legal system resulting in two different approaches to the law in the United Kingdom. England, Wales and Northern Ireland share what is generally referred to as the ‘English’ legal system, although special conditions apply to Northern Ireland. This has resulted in a rather unique set of circumstances, best described by Farmer (L Farmer, Criminal law, tradition, and legal order: crime and the genius of Scots law : 1747 to the present (Cambridge University Press 1997) 21) “…the Scottish legal system exists without its own legislative body and the British Parliament passes laws that may be administered differently within the same country.” Since Farmer wrote that, the Scottish Parliament has been established and given some law making powers but the situation remains the same for health and safety legislation which has not been devolved.
deterrence between civil and criminal fines is the potential stigma associated with the criminal label”. 13

As will be discussed in Chapter Three, the Health and Safety at Work etc. Act 1974 was never intended as a tool to punish employers and certainly was never intended as a response to workplace deaths. The ethos of the 1974 Act was the reduction of accidents and ill-health caused by work activities and the continual improvement of working conditions. There was no explicit offence of causing death, injury or ill-health, instead offences focussed on contraventions of the relevant statutory provisions, although the consequences of such offences might be taken into account during sentencing. At the time of the introduction of the 2007 Act, the 1974 Act had been in force for more than 30 years and had been considered successful in reducing deaths, injuries and ill-health in the workplace but its limitations in punishing corporations and individuals responsible for workplace deaths were becoming increasingly apparent.

In many respects, this inability to deal specifically with deaths arising from work activities is not surprising. Multi-fatality accidents are not a peculiarly late twentieth/early twenty-first century phenomena; they have occurred on a relatively regular basis since the earliest days of the industrial revolution (and probably before), but what did change in this period was the idea that organisations could be held responsible for the deaths, not just their causes which was the emphasis of the existing health and safety legislation. The Health and Safety at Work etc. Act 1974 came into force well before this change in attitude, where organisations could be considered criminally liable for deaths arising from their activities. Prior to the end of the twentieth century, there was little public demand for corporations to be punished explicitly for causing death, even in major disasters such as Aberfan in 1966 where one hundred and sixty-six people died, mainly children, after being buried under colliery spoil. The cause of the accident was attributed entirely to a failure in the way the National Coal Board managed the tip but no prosecution was taken against it, and there is no indication that a case for corporate manslaughter was ever considered. In 1974, an explosion at a chemical plant in Flixborough resulted in the deaths of twenty-

13. ‘Corporate Crime: Regulating Corporate Behavior through Criminal Sanctions’ (1979) 92 Harv L Rev 1227
eight people with a further thirty-six seriously injured. Once again, the responsibility for the explosion was attributed to the plant operators but although the accident did result in a change in regulatory control of this type of installation, there was no prosecution for corporate manslaughter, nor any suggestion that there should be.

It is beyond the scope of this thesis to consider the changes in society and societal attitudes that took place between the Aberfan and Flixborough disasters, and the Herald of Free Enterprise but there was a significant shift in the public attitude towards organisations considered responsible for deaths and in particular, multiple deaths. The concept of corporate criminal liability had been established for a number of decades before the Herald of Free Enterprise disaster and from that concept, it was held that a company could be charged with corporate manslaughter. This was confirmed by case law in the second part of the twentieth century although the case against P & O Ferries Ltd was the first corporate manslaughter prosecution recorded in England and Wales (European Ferries Ltd, the original operator of the Herald of Free Enterprise, was acquired by the P & O group shortly after the accident). The case against P & O failed, mainly as a consequence of the application of the identification doctrine which requires the identification of an individual who could be considered as representing the corporation (the “controlling” or “directing mind”) and whose direct actions were responsible for the actions leading to the deaths before a corporation could be successfully prosecuted for manslaughter. In large organisations, it was almost impossible to satisfy the identification doctrine, there were too many layers of management between the direct cause of the accident and any person who could be considered senior enough to be the “controlling mind”. The concept of “controlling mind” and the identification doctrine will be discussed in more detail in a later chapter but it made the few subsequent prosecutions for corporate manslaughter against large organisations certain to fail. That is not to say that all corporate manslaughter prosecutions were unsuccessful but the few that did succeed were in respect of very small companies where the prosecution was able to establish the “controlling mind”. This created a two tier approach to justice; because of their complexity, large organisations were effectively immune from prosecution for corporate manslaughter and most senior managers from prosecution for manslaughter but
small organisations could be prosecuted for the offence and their senior managers for manslaughter. This was clearly unfair and unjust and by itself would have justified a change in the law.

The attempts to use corporate and individual manslaughter prosecutions as a means of punishing organisations and senior managers for deaths arising from work activities could be considered an extension of the criminal law into what was previously the domain of regulation. In the cases described above and discussed in more detail elsewhere in this thesis, prosecution for manslaughter was an attempt to punish the organisations involved, perhaps attaching the stigma apparently lacking in the regulatory approach to health and safety offences. It could also be argued that the degree of harm to the victim was more properly recognised by the manslaughter charge than through the more typical health and safety offences that focussed on the causes, rather than the consequences. The stigma of a guilty verdict for a criminal offence would appear to be more important than the unlimited fines that could be imposed through the regulatory routes. There is some debate about the real impact of ‘stigma’ on an organisation, with a note in the Harvard Law Review suggesting that it is “questionable”, whilst Fisse argues that prosecution for a criminal offence “...imposes a stigma that, unlike monetary loss, cannot simply be written off as a business cost or passed on to others.” Associating stigma with bad publicity, Cahill and Cahill suggest that by itself it could be sufficient punishment for some organisations. What is generally agreed, however, is that stigma is much more likely to be attached to a criminal rather than regulatory conviction.

Before considering the Corporate Manslaughter and Corporate Homicide Act 2007 in more detail, it is worth briefly considering the range of penalties available for health and safety offences, in addition to an unlimited fine (for indictable offences). The focus so far in this introduction has been on organisations, the offences they can commit and the fines that can be levelled against them, but

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14 For example, £15 million in the case of *R v Transco plc* [2006] EWCA Crim 838; £10 million later reduced to £7.5 million in *R. v Balfour Beatty Rail Infrastructure Services Ltd* [2006] EWCA Crim 1586; [2007] Bus LR 77; [2007] 1 Cr App R (S) 65; [2007] ICR 354; (2006) 150 SJLB 922; (Court of Appeal (Criminal Division))

15 ‘Corporate Crime: Regulating Corporate Behavior through Criminal Sanctions’ op. cit. n.13, p.1230; Brent Fisse, ‘Sentencing options against corporations’ (1990) 1 Crim Law Forum 211 229

individuals at all levels of a company can also be prosecuted for a range of offences and, very importantly, prison sentences can be imposed in some circumstances. The Health and Safety (Offences) Act 2008 greatly extended and increased the penalties available to the courts in respect of both organisations and individuals found guilty of health and safety offences including imprisonment for a wider range of contraventions. The potential for the 2008 Act to be more significant than the 2007 Act to effectively address corporate killing will be an important part of this research and will be considered in depth in the final chapter of this thesis.

The introduction of a corporate manslaughter offence would prove to be neither an easy nor straightforward process, as indicated by the fact that it would be thirteen years between the initial proposals in 1994 and the introduction of the Corporate Manslaughter and Corporate Homicide Act 2007. The Act, which introduced a range of penalties for organisations found guilty of causing death as a consequence of “a gross breach of a relevant duty of care” owed by the organisation to the victim will be discussed in depth in Chapter Five.17 Importantly, the 2007 Act applies only to organisations, there is no liability imposed upon individuals although they could still be separately prosecuted for gross negligence manslaughter. The main penalty is a fine but remedial and publicity orders can also be made. The 2007 Act theoretically extends beyond what would be considered workplace health and safety issues and could include deaths arising in circumstances that would be excluded from the normal application of the Health and Safety at Work etc. Act 1974 although it is difficult to imagine any circumstances where the former would apply but not the latter, and it is fair to say that any such case would very much be the exception rather than the rule.

Perhaps one of the most significant differences between the 1974 and 2007 Acts is enforcement. The enforcement of the Health and Safety at Work etc. Act 1974 and the relevant statutory provisions (including the 2008 Act) is carried out by a number of different agencies but mainly the Health and Safety Executive for high risk activities including manufacturing and local authorities for low risk activities and the service sector, whereas the police will be mainly responsible

17 The Corporate Manslaughter and Corporate Homicide Act 2007 (c.19)
for initiating proceedings under the 2007 Act. Unlike health and safety legislation where prosecutions in England and Wales can be initiated by the various inspectorates (the situation is different in Scotland), proceedings for the Corporate Manslaughter and Corporate Homicide Act 2007 must have the consent of the Director of Public Prosecutions in England and Wales and the Director of Public Prosecutions for Northern Ireland in Northern Ireland. In Scotland, all prosecutions for indictable offences are instigated by the Lord Advocate so there is no specific provision in the Act for proceedings in that part of the United Kingdom. As stated previously, it is expected that investigations for corporate manslaughter will be led by the police but the Health and Safety Executive or other enforcing agency would also be involved where the death arose from a work activity. ¹⁸

On the basis that the main penalty available in the 2007 Act is a fine, on the face of it health and safety legislation would seem to have a wider range of penalties, including imprisonment. The penalties available through the health and safety legislation can be imposed even where there has been no personal injury or ill-health, there only needs to a contravention of one or more of the relevant statutory provisions. It could be argued that the stigma of being guilty of a ‘criminal’ rather than ‘regulatory’ offence is sufficient justification in itself for the 2007 Act, or perhaps the explicit crime of corporate manslaughter is reason enough. Alternatively it could be argued that it is mainly symbolic; the cry for something to be done was heard and that something ended up being a piece of legislation that brought very little new to the suite of enforcement options, and had almost nothing to offer in preventing accidents in the workplace. Unlike the provisions contained in the health and safety legislation, which can require improvement or prohibit dangerous activities before an accident occurs, the 2007 Act is entirely reactive, death must have occurred before its provisions come into effect. This may serve as a deterrent but it is much more likely that its main function will be to punish those few organisations found guilty of corporate manslaughter. The senior managers of the largest organisations will be no more likely to be personally liable for gross negligence

¹⁸ Ministry of Justice, A guide to the Corporate Manslaughter and Corporate Homicide Act (The Stationary Office 2007) 18
manslaughter than before whereas the senior managers of the smallest companies will be just as vulnerable.

The relevance of the Corporate Manslaughter and Corporate Homicide Act 2007 must also be considered in the context of the subsequent Health and Safety (Offences) Act 2008. As stated previously, unlimited fines have always been available for certain contraventions of the Health and Safety at Work etc. Act 1974 but the range of offences subject to imprisonment has been greatly increased, perhaps making the 2008 Act a more significant piece of legislation for the improvement of worker safety than the 2007 Act, and possibly a more effective means of punishing corporate killing. The 2008 Act was never intended to address the shortcomings of the 2007 Act, but it does allow senior managers to be prosecuted for workplace deaths, irrespective of the size of the organisation although in the largest companies it will always be a challenge to prove liability. Unlike the 2007 Act, the Health and Safety (Offences) Act 2008 could be used in circumstances where deaths or serious injuries could have occurred but did not, the ‘near-misses’. Addressing these ‘near-misses’ has always been an important part of improving the safety of workers and other people who may be affected by work activities.

This thesis will examine the relationship between the Corporate Manslaughter and Corporate Homicide Act 2007 and the Health and Safety (Offences) Act 2008 focusing on their very different approaches to addressing work-related deaths. It is fair to say that the 2007 Act has got off to a slow start, with few prosecutions in England and Wales and none in Scotland, so its actual impact on corporate behaviour is still a matter for conjecture. As discussed, unlimited fines for certain offences have always been available for contraventions of the Health and Safety at Work etc. Act 1974 and its relevant statutory provisions, but the introduction by the 2008 Act of the possibility of a custodial sentence for a much wider range of offences could make it a more effective deterrence to those individuals who may be responsible for the circumstances that could lead to a workplace fatality, rather than the 2007 Act which can only punish the organisation itself. In essence, it is a question of whether it is more of a deterrence to imprison an individual who carries some personal responsibility for the death (and such a penalty would almost always be associated with a fine for
their company) or to only fine the organisation (“corporation”) but with a stigma associated with “true” crime, that might not be associated with regulatory penalties.

The aim of this research can be condensed into a number of research questions which will be answered in the final chapter:

1. **Why has the Health and Safety at Work etc. Act 1974 and its predecessors been perceived to have failed to effectively address the criminal behaviour of organisations resulting work related deaths?**
2. **Why were the high profile corporate manslaughter cases arising from work related fatal accidents in the latter half of the twentieth century and the early part of the twenty-first century unable to result in a successful prosecution?**
3. **Will the Corporate Manslaughter and Corporate Homicide Act address the apparent or perceived shortcomings in the current approach to prosecution for corporate manslaughter following work related deaths?**
4. **Is the Corporate Manslaughter and Corporate Homicide Act ‘symbolic’ rather than ‘instrumental’ and if so, is it an appropriate approach to dealing with workplace safety?**
5. **With the introduction of the Health and Safety (Offences) Act 2008, has the “regulatory” approach finally been given the means necessary to properly address its previous perceived shortcomings and made the Corporate Manslaughter and Corporate Homicide Act irrelevant?**

To properly understand and appreciate the current approach to work-related deaths, it is necessary to analyse the origins and nature of health and safety legislation in the United Kingdom. Chapter Two investigates the historical context of legislation intended for worker protection with Chapter Three examining the current state of safety regulation in the context of its ability to effectively address the most serious workplace accidents. Chapter Four introduces and examines the concept of corporations and corporate killing with Chapter Five going on to analyse and assess the background and nature of the Corporate Manslaughter and Corporate Homicide Act 2007 and its impact since its introduction.
Chapter Six examines the actual and apparent distinction between “true” criminal law and regulatory law. This apparent distinction is a very important part of this research since the 2007 Act would be categorised as “criminal” in nature, whereas the 2008 Act would generally be described as “regulatory”.

Some of the implications for this distinction have already been touched upon in this Chapter and they will be discussed in much more detail in Chapter Six. Chapter Seven will consider the arguments presented throughout this thesis and draw conclusions, focussing on the implementation, impact and effectiveness in reducing workplace deaths of both the Corporate Manslaughter and Corporate Homicide Act 2007 and the Health and Safety (Offences) Act 2008.
2.0 Regulation of Workplace Safety in the UK

2.1 Introduction

The Corporate Manslaughter and Corporate Homicide Act 2007 and Health and Safety (Offences) Act 2008 can only be properly considered in the context of the history of health and safety legislation in the UK. Whilst the 2007 Act covers fatalities arising from corporate activities other than work, it is inevitable that work-related deaths will form the vast majority of cases, a fact recognised by the Act itself, which makes specific reference to breaches of health and safety legislation.\textsuperscript{19} Accordingly, this Chapter will examine the development of health and safety legislation in the United Kingdom from the earliest days of the industrial revolution through to the Robens Report of the nineteen-seventies, which resulted in the Health and Safety at Work etc. Act 1974, the most significant change to health and safety regulation in almost two centuries of legislative worker protection.\textsuperscript{20} An analysis of the evolution of worker safety legislation in the nineteenth and twentieth centuries will help to explain the perceived inadequacies of health and safety regulation in the late twentieth century and the assumed need for a more robust approach to deaths arising from work activities which ultimately resulted in the 2007 Act.

Industrialisation of the United Kingdom in the late eighteenth and early nineteenth centuries brought many benefits but also many challenges which the societal structures of the time were unable to meet. Mass migration from the countryside to the industrial towns and cities resulted in overcrowded and disease-ridden slums where workers lived a short, and in many cases, brutal life.\textsuperscript{21} Conditions in the workplace were, more often than not, just as bad if not worse than those at home but with the additional hazards of occupational illness and accidents which often resulted in serious injury or death.\textsuperscript{22} The only recourse available to workers and their families in these circumstances was an action in common law or the law of master and servant, which will be discussed

\textsuperscript{19} The Corporate Manslaughter and Corporate Homicide Act 2007 (c.19) Sections 8, 9
\textsuperscript{20} Robens, Safety and Health at Work. Report of the Committee 1970-72, 1972
\textsuperscript{21} Frederick Engels, The Condition of the Working-Class in England in 1844 With a Preface written in 1892 (George Allen & Unwin Ltd. 1892) 26
\textsuperscript{22} Ibid
later in this section. This Chapter will discuss how the development of legislation to improve working conditions was both piecemeal and haphazard, and perhaps not, or not only, as the result of “Tory Philanthropy” as suggested by Dicey.\textsuperscript{23} The theory that safety legislation was of greater benefit to employers rather than the people it was intended to protect will be introduced in this Chapter and expanded upon in Chapter Six where the theories of crime and regulation are discussed in more depth and their apparent distinction addressed.

The introduction of the first Factories Act in 1802 and the subsequent appointment of factory inspectors in 1833 heralded state intervention for the protection of worker safety by means of legislation as the norm in the United Kingdom. This Chapter will consider the effectiveness of this approach with subsequent chapters examining whether or not deaths directly attributable to the actions of employers could, or should, be described as murder, or at the very least, manslaughter or culpable homicide, as proposed by various commentators over the past two centuries.\textsuperscript{24} As this Chapter will illustrate, the perceived failure of the law to properly hold employers to account for workplace deaths has been a feature since the very earliest days of the industrial revolution, a failure that was never properly addressed during the nineteenth and twentieth centuries. From the very first Factories Act of 1802 through to the Robens Report of 1972, there has been a distinct lack of accountability attached to employers in respect of deaths arising from their activities. The reasons for this situation can only be properly understood by examining the development of workplace safety laws from the very earliest days of industrialisation in the context of the social and industrial norms of the time. This Chapter will examine the background to the first Factories Acts and their subsequent evolution through the nineteenth and twentieth centuries,

\textsuperscript{23} A.V. Dicey, Lectures on the Relation between Law and Public Opinion in England during the Nineteenth Century (Liberty Fund 2008)
\textsuperscript{24} John Mitchell, Treatise on the Falsifications of Food, and the Chemical Means to Detect Them (Hippolyte Bailliere 1848) 122 Mitchell was referring to food adulteration rather than workplace safety but what he was referring to would certainly fall under the category of corporate killing; ‘Chips’, Deadly Shafts op. cit. n.1, p.494; Andrew Hopkins, ‘Social Values in Occupational Safety Law’ (1989) 13 Legal Studies Forum 135 140; Jones, ‘Safety Crime: a case study of Transco’ op. cit. n.7, p.19; Punch, ‘Suite violence: Why managers murder and corporations kill’ op. cit. n.7, p.273; Steven Bittle and Laureen Snider, ‘From Manslaughter to Preventable Accident: Shaping Corporate Criminal Liability’ (2006) 28 Law & Policy 470 489
culminating in the Robens Report which led, in turn, to the Health and Safety at Work etc. Act 1974. Best described as a series of responses by the establishment to changing circumstances arising from industrialisation, much of the resulting legislation benefitted employers more than employees.

2.2 Before the Factories Acts

Whilst there can be no doubt that pre-industrial revolution workers and others died as a result of work activities, there is very little information available about how and why. Relatively large scale manufacturing had been established in various parts of the United Kingdom by the end of the eighteenth century but few details of workplace deaths exist. Prior to the nineteenth century there was no mechanism for distinguishing between deaths occurring as a result of workplace activities and those arising from non-work related accidents but it must be assumed that many workers died as a result of their employment whether through accident or ill-health. Agricultural workers would have been exposed to a range of work related diseases, extremes of weather and injuries from working with livestock; miners from fire, explosion, roof collapse, etc., builders from falls from height, being struck by falling objects, etc., watermen from drowning, and so on. Whilst some of these deaths would have been recorded in newspapers, the vast majority would have been significant only to their families, fellow workers and employers.

That is not to say that workplace hazards were completely ignored. One example of an invariably fatal work related disease from the eighteenth century was the occurrence of scrotal cancer amongst chimney sweeps and their apprentices. The disease was observed by Pott towards the end of the eighteenth century when he made the association between occupation and illness. This is not the only example of such an association being made

27 Percival Pott and James (Sir) Earle, The chirurgical works of Percival Pott. to which are added a short account of the life of the author, a method of curing the hydrocele by injection and occasional notes and observations by Sir James Earle, vol III (Wood and Innes 1808)
between disease and work, or even the first, but it is one of the best known. The first piece of legislation in the UK dealing specifically with poor working conditions was the 1788 Act for the better Regulation of Chimney Sweepers, and their Apprentices.\(^{28}\) It was not introduced in response to Pott’s work but as a result of the general outcry against the working conditions of what were referred to as *climbing boys*, or chimney sweepers’ apprentices. Children (girls as well as boys) as young as five were taken on by chimney sweepers to assist in the cleaning of chimneys.\(^{29}\) The smaller the child the better, since they were expected to climb into the confined spaces of chimneys and flues to clean accumulations of soot. The work was dirty and dangerous, with many of the children dying from asphyxiation, burns or falls.

The 1788 Act was relatively straightforward in that it contained two main provisions; no apprentice to be employed under the age of eight, and chimney sweepers to have no more than six apprentices at one time. Although penalties were included in the Act, there was no enforcement provision other than for Justices to hear complaints. The Act contained no requirement to improve working conditions or for the welfare of the apprentices. As could be expected from a piece of legislation containing no enforcement provision, the Act was unsuccessful. In 1834, Roberts reported:-

> “Climbing boys being forced up chimneys by goads and flames - of them being scarified, bruised, flogged and crippled - having their nails torn off - their eyes inflamed-their growth stinted, and their limbs distorted - of their sufferings and death from the cureless cancers - of their being suffocated, baked, burnt, and scalded to death - of their being dashed to pieces in pots falling from the tops of the highest chimneys - and dying from disease and want and misery by the highway side,...” \(^{30}\)

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\(^{28}\) An Act for the better Regulation of Chimney Sweepers, and their Apprentices 1788 (28 Geo 3 c48)


\(^{30}\) Samuel Roberts, *An address to British females of every rank and station, on the employment of climbing boys in sweeping chimneys* (Whitaker & Co. 1834) 13
It would be the latter half of the nineteenth century before the employment of children in this industry was finally ended.\textsuperscript{31}

In England and Wales in the eighteenth and nineteenth centuries, the employer’s responsibility to his employees in the event of an accident at work extended only so far as his benevolence or the common law allowed. If an employer’s personal negligence was the cause of an accident resulting in injury (but not death), the victim or the victim’s personal representative could sue for damages at common law, although there is no recorded case of an employer being sued for injuries to employees prior to 1837, either successfully or unsuccessfully.\textsuperscript{32} The situation for the families of workers killed at work due to negligence by their employer was even worse since they were unable to sue for damages. In \textit{Baker v. Bolton}\textsuperscript{33} it was held that the death of a person could not be considered an injury and consequently the right of action was unavailable where that death arose as the result of a tort. Holdsworth suggested that this decision was, at best, illogical, but it was not until the \textit{Fatal Accidents Act 1846} that personal representatives (wife, husband, parent, grandparents, children, grandchildren, step-parents and step-children) of the deceased were given the right to take legal action for the loss arising from the death of a person caused by “…wrongful act, neglect, or default…” where the victim would have been able to take action for damages if they had been injured, rather than killed.\textsuperscript{34} Although not specifically referred to in the 1846 Act, the doctrine of common employment (discussed later in this section) was successfully used by defendants, significantly reducing the effectiveness of the Act in providing compensation for the dependants of the victims of fatal workplace accidents. The position in Scotland was quite different, where both patrimonial loss and \textit{solatium} could provide an award to the victim’s family following a death arising from the negligence of employers. Patrimonial loss referred to the economic loss arising from dependency, and \textit{solatium} recognised the grief and suffering arising from the loss.\textsuperscript{35} Unlike the doctrine of common employment mentioned previously and discussed in more detail in the following paragraphs, this distinction between

\textsuperscript{31} Phillips, ‘The Abolition of Climbing Boys’ op. cit. n.29, p.462
\textsuperscript{32} \textit{Priestley v. Fowler} (1837) 150 Eng Rep 1030 1220- 1865 1032
\textsuperscript{33} \textit{Baker v Bolton & Ors} [1808] EWHC KB J92
\textsuperscript{34} W. S. Holdsworth, \textit{A History of English Law}, vol III (3rd edn, Methuen 1922) 334; \textit{Fatal Accidents Act 1846} (9 & 10 Vict. c.93)
\textsuperscript{35} Hector Burn Murdoch, ‘English Law in Scots Practice III’ (1909) 21 Jurid Rev 148 150;

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Scots law and that of England and Wales was retained well into the twentieth century.

The traditional master-servant relationship based on status, continued to be the norm well into the eighteenth century, with the master being expected to take on responsibility for servants injured as a result of work activities. As the eighteenth century drew to a close, this relationship was increasingly being seen in terms of contract rather than status. Maine described the move from status, where the rights and duties of an individual are determined by their class or position in society, to contract as an indication of a progressive society. Although Graveson disagreed with Maine’s theory of progress being measured by the move from status to contract, suggesting instead that an element of contract had always existed in feudalism, the development of the Factories Acts in the nineteenth century could at least partly be explained by the change of emphasis “...from one of reason to one of individual liberty”.

The emphasis of the early Factories Acts on the protection of women and children almost to the complete exclusion of male workers can be explained by contractual relationship, or lack of it, between employers and the employed. Male workers, in accepting a contract of employment, were deemed to accept all the risks and hazards associated with the work, *volenti non fit injuria*. This had the consequence that employers could not be held liable for injury arising from activities associated with the work, at least so far as a male workers were concerned. As a consequence of society and the law assuming them unable to form a judgement of their own interests and/or having inferior bargaining power which could lead to them being exploited by others, women and children were not considered capable of entering the same type of contractual arrangement as men. As stated previously, this distinction between male workers and females and children was significant in the evolution of factories legislation in the nineteenth century. It should be noted that both Graveson and Kahn-Freund

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36 Bronstein, *Caught in the Machinery. Workplace Accidents and Injured Workers in Nineteenth-Century Britain*. op. cit. n.25, p.27
37 R. H. Graveson, 'The Movement From Status To Contract' (1941) 4 The Modern Law Review 261 264
39 Graveson, 'The Movement From Status To Contract' op. cit. n.37, p.263, 265
suggested that what actually transpired was a reversal of Maine’s theory, with the movement from contract to status particularly in certain aspects of employment including worker safety.\textsuperscript{41}

In the early part of the industrial revolution, the extent of an employer’s responsibility for his employee’s safety was established in the case of \textit{Priestley v. Fowler} which was brought in respect of injuries incurred by an employee when the cart he was driving collapsed. The injured party, Priestley, sued his employer, Fowler, for damages arising as a consequence of the accident. The case, first heard at the Lincolnshire Summer Assizes in 1837, found in Priestley’s favour and he was awarded £100 in damages. On appeal by Fowler, the original judgement was overturned on the basis that he was not liable for the injuries incurred by Priestley. In finding in favour of the appellant, Abinger, C.B. declared that there was no duty imposed on a master to look out for the safety of his servant, or for any injury arising from circumstances that he had no knowledge of including injury caused by a fellow employee.\textsuperscript{42} In addition, he held that a servant can decline any service where he may suffer injury and conversely, the servant or employee is deemed to have accepted any inherent risks as part of the contract of employment with remuneration made accordingly. In effect, the duty of the master or employer extended only so far as “...to provide for the safety of his servant in the course of his employment, to the best of the judgement, information and belief” although even this limited responsibility seems to have been lost in the interpretation of his comments elsewhere in this judgement.\textsuperscript{43}

Abinger, C.B.’s judgement established the principle that the employer would only be liable for injuries arising from his own direct actions and would have no liability for the actions of any of his employees so long as he was not negligent in their selection. This became known as the doctrine of Common Employment (also known as the Fellow-Servant rule in the US). The principles established in \textit{Priestley v. Fowler} had very long-term consequences for employees injured whilst at work and subsequent cases reinforced and extended this rule. The common employment doctrine was applied in the US as well as the UK and by

\textsuperscript{41} Ibid; Graveson, ‘The Movement From Status To Contract’ op. cit. n.37, p.263 et seq
\textsuperscript{42} \textit{Priestley v. Fowler} op. cit. n.32, p.1032
\textsuperscript{43} Ibid
1888, Hobbs described it as being “bitterly opposed” (although he failed to say by whom) and based upon circumstances that had ceased to exist. Described by Glazebrook as a “monstrous doctrine”, common employment was considered by Graveson as the “...judicial response to the demand of employers for a reduction of the vastly increased Common Law liabilities imposed upon them by the employment of hundreds upon machines...”. With the enormous changes in working practices brought about by the Industrial Revolution, employers were clearly fearful that they would be liable to pay compensation for injuries and deaths occurring in their factories where workers would be exposed to a wide range of hazards from moving machinery and other dangerous activities. This view was supported by Cornish and Clark who suggested that the common employment doctrine was a judgement that the costs of accidents were something that could not and should not be met by a developing industry which perhaps is a reflection on the priorities of both industry and state.

In Scotland, at least for the first half of the nineteenth century, the Common Employment doctrine was not applied if the accident was caused by the negligence of an employee to whom the employer had delegated at least part of his authority. This continued until 1858 when the doctrine of common employment was imposed on Scotland by the judgement reached by Lord Cranworth in the case of Bartonhill Coal Co. v. Reid. Contrary to the clear wishes of the Scottish Courts explicitly stated in the judgement in Dixon v. Rankin and in other cases, Lord Cranworth held that there was “...no clear settled course of decision in Scotland,...” preventing a similar approach to common employment being taken in both countries. This imposition was still worthy of comment almost 40 years later when Williamson observed “...the Scots...
Courts did not accept the English law of ‘Common Employment’ till it was thrust upon them by the House of Lords."\(^{50}\) Priestley v. Fowler and subsequent cases made it almost impossible for employees to sue their employers for injuries arising from work unless they could show that they were caused by the personal negligence of their employer.\(^{51}\) Howells suggested that by linking the doctrines of common employment and *volenti non fit injuria*, there was an “acceptance of all risks in consideration of wages.”\(^{52}\)

The defence of common employment was not available to employers where the injury resulted from the breach of a statutory duty; in such cases the injured party could sue his or her employer for damages.\(^{53}\) Although the common employment defence gradually diminished as additional statutory duties were introduced throughout the nineteenth and early twentieth century, it, along with assumed risk and contributory negligence, made it virtually impossible for an injured worker to sue his or her employer.\(^{54}\) The common employment defence was only slightly diminished through the introduction of the Employers Liability Act of 1880 and it would be almost a further seventy years before it was entirely eliminated by the Law Reform (Contributory Negligence) Act 1948.\(^{55}\)

The development of common employment, assumed risk and contributory negligence in the nineteenth century is evidence that workers could not rely upon the common law to offer any protection or compensation against workplace accidents and disease and most employers showed very little sign of addressing these issues voluntarily. It would be many years before workers achieved any real entitlement or expectation of a safe place of work, something eventually achieved through legislation, as will be discussed in the next section.


\(^{51}\) Pease, ‘An English Workman’s Remedies for Injuries Received in the Course of His Employment, and Common Law and Statute’ op. cit. n.47, p.512


\(^{53}\) Pease, ‘An English Workman’s Remedies for Injuries Received in the Course of His Employment, and Common Law and Statute’ op. cit. n.47, p.512

\(^{54}\) Bronstein, *Caught in the Machinery. Workplace Accidents and Injured Workers in Nineteenth-Century Britain*, op. cit. n.25, p.30

2.3 The Factories Acts

The “Factories Acts” is the collective term used for a series of acts implemented from the start of the nineteenth century through to the middle of the twentieth century that were intended to improve the conditions of those working in factories and similar manufacturing premises. As this Chapter will show, the development of the Factories Acts was more evolutionary than revolutionary with each iteration consolidating previous additions and amendments, but also reacting to changes in working practices, the introduction of new hazards and changes in society’s attitudes towards poor working conditions.

In the twenty-first century, it would generally be considered that legislation to improve workplace health and safety was introduced for the benefit of workers. Equally, it would be fair to assume that its introduction was not in the interests of employers and would have been resisted by them, particularly in the nineteenth and early parts of the twentieth century. In a series of influential articles published from the nineteen-seventies onwards, Carson proposed a contrary viewpoint, suggesting that early factory legislation in the UK was supported and encouraged by some of the larger manufacturers of the time.\(^{56}\) The reasons for this would include altruism but as argued by Baines, it would also be profitable to the employer to have “...a moral, sober, well-informed, healthy and comfortable body of workers.”\(^{57}\) As will be discussed later in this Chapter, there was also an element of anti-competitiveness in the behaviour of some of the mill owners supporting this legislation; what was proposed would be more difficult for the smaller mills and factories located in rural areas to comply with than the larger ones located in towns and cities. The view that governments did not always have the best interests of those they governed in mind when creating laws and institutions was commented upon by Bentham who stated that “Government has, accordingly, under every form comprehending laws and institutions, had for its object the greatest happiness, not of those over whom, but of those by whom, it has been exercised; the interest not of the

\(^{56}\) W.G. Carson, ‘The Sociology of Crime and the Emergence of Criminal Laws’ in Paul Rock and Mary McIntosh (eds), *Deviance and Social Control* (Deviance and Social Control, Tavistock Publications 1974) 74

\(^{57}\) Edwards Baines, *History of the Cotton Manufacture in Great Britain* (Fisher, Fisher and Jackson 1835) 484
many, but of the few, or even of the one, has been the prevalent interest; and to that interest all others have been, at all times, sacrificed". 58 This would support the view that the regulation of working conditions was achieved with the consent of factory owners with their profits in mind, instead of (or as well as) the altruism of social reformers being the primary motivating factor. The concept of regulation being for the benefit of the regulated rather than those it was purported to protect has evolved over the years into the private theory of regulation which will be discussed in more detail in Chapter Six.

The first efforts to improve working conditions for factory workers were a by-product of the efforts to control the hours of work of children and other young people and prevent the outbreak of disease amongst factory workers. What was subsequently referred to as the first Factories Act was introduced in 1802 although concern over working conditions, particularly for children and young people had been expressed a number of years previously. Concern about the conditions in factories in England was first recorded by the Manchester Board of Health in 1795 which was established following an outbreak of typhoid fever. In the Resolutions for the consideration of the Manchester Board of Health (reproduced in Peel’s Report of 1816), Percival identified a number of concerns, some of them directly related to the outbreak of disease, some dealing with other conditions. 59 In particular, Percival expressed concern that overcrowding in cotton factories and the workers’ housing was a significant cause of the spread of infectious disease amongst children and others working in the factories and the general working conditions within the factories were injurious to health. The long working hours during daytime and night working were considered harmful to children’s health (Percival also commented on how their children’s earnings encouraged parents to “…idleness, extravagance and profligacy...”) and there was little, if any, education or religious instruction provided to children working in the cotton factories. Percival did point out that there was good practice in some cotton factories where most of the issues raised in his report were avoided or minimised.

59 Robert Peel, Sir, Report of the minutes of evidence, taken before the Select Committee on the State of the Children Employed in the Manufactories of the United Kingdom. (House of Commons Papers; Reports of Committees, 1816) 139
Sir Robert Peel (also the owner of a mill where children were employed including at night and which had particularly bad working conditions), partly as a consequence of Percival’s report, his own experiences and other examples of poor working conditions, introduced a bill in 1802 for the Better Protection of the Health and Morals of Apprentices.\(^{60, 61}\) The Health and Morals of Apprentices Act 1802 was subsequently passed without any significant opposition.\(^{62}\) The 1802 Act applied to mills and factories (but only textile and woollen mills and factories) in Great Britain and Ireland where three or more apprentices or twenty or more other persons were employed at one time.\(^{63}\) The requirements of the Act were not particularly onerous and included that walls and ceilings be washed twice each year with quicklime and water; that windows sufficient for adequate ventilation be provided; that apprentices be supplied with two complete suits of clothing, with one new suit provided at least once each year; that no apprentice work for more than twelve hours a day, exclusive of time for meals, and the hours of work must be between 6.00am and 9.00pm; separate sleeping compartments for males and females and no more than two in a bed; that arrangements be made in specified circumstances for education and religious instruction; and that visitors were empowered to call in a physician in the event of becoming aware of any infectious disease occurring in a factory. Many of the concerns raised by Percival were, in theory, addressed by this Act although as will be discussed below, in reality it had little impact on the conditions in mills and factories. Enforcement was to be carried out by two visitors appointed by a Justice of the Peace. One of the visitors was to be a Justice of the Peace and the other a clergyman of the established Churches of England or Scotland. The penalty for committing an offence was a fine not less than 40 shillings and not exceeding £5.\(^{64}\)

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\(^{60}\) Maurice Walton Thomas, *The Early Factory Legislation. A Study in Legislative and Administrative Evolution* (The Thames Bank Publishing Company 1948) 8

\(^{61}\) An Act for the preservation of the Health and Morals of Apprentices and others, employed in cotton and other mills, and cotton and other factories 1802 (42 Geo 3 c73)


\(^{63}\) An Act for the preservation of the Health and Morals of Apprentices and others, employed in cotton and other mills, and cotton and other factories 1802 (42 Geo 3 c73)

\(^{64}\) Ibid
The 1802 Act was not a success, “...fore-doomed to failure, and it was in fact, totally ineffective”.65 The system of ‘visitors’ was ineffective, with little incentive for them to do much more than a cursory visit. The nature of the local community would have put the visitors in the same social circles as the mill and factory owners, an obvious disincentive to robust enforcement.66 McDonagh was even more critical of the system of visits by local justices of the peace, suggesting that they “...might be ignorant, lazy, cowardly or self-interested...”67 Many of the mills and factories were in fairly isolated areas and in “...many parts of the country, it seems, the very existence of the Act was unknown” 68 As Brebner put it, “...the first Factory Act achieved little to protect ‘the health and morals of apprentices’ in textile factories”.69 Hutchins and Harrison suggested that the 1802 Act had more in common with Elizabethan Poor Law as it related to parish apprentices rather than “...the conscious assumption of control over industry”. 70 They argued that the Government had taken on the responsibility for raising and placing out children into factories and consequently was compelled to try to regulate their working conditions, which had a striking similarity to the consequences of the Poor Relief Act 160171 where orphan and pauper children could be apprenticed to various trades. The focus on the morals and welfare of the apprentices, rather than safety, gave the 1802 Act a very different emphasis from later Factories Acts and did very little to improve the conditions for workers in factories and mills.

The next attempt to improve conditions for factory workers, particularly in respect of children, was once again led by Sir Robert Peel who introduced a Bill in 1815 to extend the protection afforded by the 1802 Act to the so-called ‘free children’ who lived locally and did not fall under the category of ‘apprentices’.72 This Bill encountered much more resistance from mill-owners and it was referred

65 Thomas, The Early Factory Legislation. A Study in Legislative and Administrative Evolution op. cit. n.60, p.12
67 Oliver MacDonagh, Early Victorian Government 1830 - 1870 (Weidenfeld and Nicolson 1977) 23
68 Thomas, The Early Factory Legislation. A Study in Legislative and Administrative Evolution op. cit. n.60, p.13
69 J. Bartlett Brebner, ‘Laissez Faire and State Intervention in Nineteenth-Century Britain’ (1948) 8 The Journal of Economic History 59 70
70 Hutchins and Harrison, History of Factory Legislation op. cit. n.62, p.16
71 Poor Relief Act 1601 (43 Eliz 1 c 2)
72 Ernst Plener, The English Factory Legislation; From 1802 Till the Present Time (Chapman and Hall 1873)
for further consideration to a select committee which reported in 1816.\(^{73}\) One of the provisions in the Bill that did not survive was the appointment of ‘duly’ qualified and independent visitors to ensure enforcement with payment being made to the visitors from the public purse to cover their trouble and expenses.\(^{74}\)

Although this provision was removed during the journey of the Bill through Parliament, it did anticipate the eventual introduction of factory inspectors. The Bill was enacted in 1819, although according to Henriques it was substantially emasculated during its passage through Parliament.\(^{75}\) It did extend a lesser degree of protection to ‘free children’, at least so far as hours of work were concerned but its application was limited to cotton mills.

The subsequent Factories Acts of 1825 and 1831 were both intended to control the working hours of young people but a lack of effective enforcement provision meant they were no more effective than previous Acts. The movement for a ten-hour working day for children and young people which started in Yorkshire in 1825, gained momentum in 1830 with the establishment of the Short Time or Ten-Hour movement.\(^{76}\) The two issues of child employment and workplace regulation were inexorably linked in the early days of factory legislation and would continue to be so for decades to come. The Act of 1831 was no more successful in reducing the hours of work for most children and young people than earlier legislation, mainly due to the lack of enforcement provisions and it did not satisfy the demands of the Short Time Movement. Controversy over the actual conditions of child workers continued to grow and a Select Committee, which reported in 1832, was set up to investigate the extent of child labour in mills and factories.\(^{77}\) At least some of the evidence collected by the Committee was read by Lord Ashley who offered his services to lobby for the ten-hour day for children and young people and he introduced a Bill in 1833 to limit the

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\(^{73}\) Peel, *Report of the minutes of evidence, taken before the Select Committee on the State of the Children Employed in the Manufactories of the United Kingdom*. op. cit. n.59

\(^{74}\) House of Commons, *A bill to amend and extend an act, made in the 42d year of His Present Majesty, for the preservation of the health and morals of apprentices, and others, employed in cotton and other mills, and cotton and other factories*. (1814-15)

\(^{75}\) Henriques, *The Early Factory Acts and their Enforcement*. op. cit. n.66, p.3

\(^{76}\) Thomas, *The Early Factory Legislation. A Study in Legislative and Administrative Evolution*. op. cit. n.60, p.34; Henriques, *The Early Factory Acts and their Enforcement*. op. cit. n.66, p.4

\(^{77}\) Thomas, *The Early Factory Legislation. A Study in Legislative and Administrative Evolution*. op. cit. n.60, p.40
number of hours that young people could work in factories.\textsuperscript{78} Once again, the emphasis was on hours of work but Ashley’s Bill contained a number of other, more controversial, measures including a proposal to prosecute for manslaughter the occupier of a mill where a death of a child or young person had occurred as a consequence of the culpable negligence of the occupier in failing to guard machinery. This would appear to be the first attempt to create a mechanism that would allow for the prosecution of employers for manslaughter following a workplace death, albeit in limited circumstances. Although Ashley’s Bill proposed severe penalties, there was still no effective enforcement mechanism included amongst its measures.\textsuperscript{79}

Althorp, Chancellor of the Exchequer at the time, declared the intention of the Government to bring its own measures to deal with child labour causing Ashley to abandon his Bill.\textsuperscript{80} Prior to any Government Bill being introduced, however, a new Royal Commission was established to examine the employment of children in factories.\textsuperscript{81} Three commissioners were appointed, including Edwin Chadwick, and they were supported by local assistant commissioners who collected information in the manufacturing districts of Great Britain and Ireland. The timescale for reporting was very short but after gathering evidence the Royal Commission published its report on 1st August 1833.\textsuperscript{82} The report focussed on the employment of children and young people but it also included recommendations in respect of guarding dangerous parts of machinery and providing compensation for workers injured through no fault of their own. Importantly, the Commission proposed the establishment of an inspectorate to undertake the enforcement of any subsequent legislation. The Commission made reference to fatal injuries arising through wilful negligence but declined to make any recommendations in their respect.

\textsuperscript{78} 3 Will. IV.-Sess. 1833. A bill to regulate the labour of children and young persons in the mills and factories of the United Kingdom.
\textsuperscript{79} MacDonagh, \textit{Early Victorian Government 1830 - 1870} op. cit. n.67, p.33
\textsuperscript{80} Hutchins and Harrison, \textit{History of Factory Legislation} op. cit. n.62, p.55
\textsuperscript{81}Ibid
\textsuperscript{82} Thomas Tooke, \textit{Factories Inquiry Commission. First report of the Central Board of His Majesty's commissioners appointed to collect information in the manufacturing districts, as to the employment of children in factories, and as to the propriety and means of curtailing the hours of their labour: with minutes of evidence, and reports by the district commissioners.} (HOUSE OF COMMONS PAPERS; REPORTS OF COMMISSIONERS (450) XX1, 1833)
Chadwick subsequently produced a Government bill in 1833 incorporating most of the recommendations of the Commission.\(^83\) That Bill was amended in the Lords, removing the power of the inspectors to establish schools, and it was enacted in 1833 as the *Act to regulate the Labour of Children and young Persons in the Mills and Factories of the United Kingdom*. Once again, the legislation only applied to textile factories and mills (and even then, some types were excluded, including lace factories) and the emphasis was on the hours of work of children and young people. All of Ashley’s more controversial measures contained in his Bill of the same year, including any possibility of mill owners or occupiers being prosecuted for manslaughter for deaths arising from work, were omitted from the 1833 Act which was a shadow of Chadwick’s first Bill, and bore almost no resemblance to Ashley’s earlier effort. Even the aim of improving children’s working hours was only partly achieved and there was certainly no requirement in respect of compensation in the event of a workplace injury or guarding of dangerous machinery. As MacDonagh suggested, it was “...in many respects a failure” continuing the tradition established by the previous three attempts at legislation to improve working conditions.\(^84\)

There was a strong movement to improve working conditions, particularly of children, but Marvel suggested a different interpretation of the events leading to the 1833 Act.\(^85\) He proposed that it “was drafted at the behest of the leading textile manufacturers” with the intention of increasing the cost of production of smaller mills and factories, reducing their output and as a consequence increasing the costs of textiles and increasing profits. The 1833 Act would have serious consequences for rural water driven mills which were more reliant on children than the large urban steam-powered mills. Marvel’s argument supports Carson, discussed previously, who suggested that early factories legislation was generally supported by factory and mill owners for their own benefits rather than any consideration of their workers.

The 1833 Act heralded a new era of State involvement in areas never before the subject of regulation. Its main provisions still related to children and young

\(^{83}\) 3 Will. IV.--Sess. 1833. A bill to regulate the labour of children and young persons in the mills and factories of the United Kingdom. op. cit. n.78
\(^{84}\) MacDonagh, *Early Victorian Government 1830 - 1870* op. cit. n.67, p.49
people including the prohibition of night work between the hours of 8.30 pm and 5.30 am for all under the age of eighteen employed in cotton, woollen, worsted, hemp, flax, tow, linen or silk mills; no person under eighteen years of age to be employed for more than twelve hours/day or sixty-nine hours in a week; no child younger than nine to be employed except in silk mills; no person younger than thirteen to be employed for more than nine hours in one day or more than forty-eight hours a week; persons restricted to a twelve hour day to be allowed one and a half hours per day for meals which must be elsewhere than the machinery room or mill. 86 Provision was to be made for the education of children who were restricted to forty-eight hours work per week but as discussed previously, the removal of the power of inspectors to establish schools still meant that many children were excluded from education due the absence of suitable facilities. Where education was provided by the employer and authorised by the Inspector, a penny in the shilling could be deducted from the child’s weekly wages to go towards its provision.

Without question, the most significant aspect of the 1833 Act was the introduction of four Inspectors for its enforcement. The failure of the enforcement regime introduced by the 1802 Act was widely recognised and the appointment of Government Inspectors was felt to be the only way to ensure at least some level of enforcement (although their subsequent performance was somewhat inconsistent and there has been some debate about their effectiveness). 87 Effective or not, the appointment of the inspectors marked a fundamental change in the relationship between state and industry. Although it would take a further century and a half for all sectors of employment to be fully regulated by the state, at least so far as health and safety was concerned, the impact of the 1833 Act was to change not just the relationship between the state and industry but also between employers and employees.

86 An Act to Regulate the Labour of Children and young Persons in the Mills and Factories of the United Kingdom 1833 (3&4 Will. 4 c.1)
Worker protection afforded by the 1833 Act was mainly restricted to controlling hours of work of children and apprentices with only a marginal impact on the work environment and working conditions. Although the Commission recommended a system of compensation for children and operatives injured whilst at work (for the latter it had to be shown that the injury arose through no fault of their own) it was not included in the Act.  

If the requirement for compensation had been included in the 1833 Act, Thomas suggests that it would have removed the need for legislation to deal with machinery guarding and other safety issues. His argument is based on the assumption that if employers were responsible for paying compensation in the event of worker being injured by dangerous machinery, there would have been a financial incentive to remove the hazard which could have eliminated the need for the legislative approach that developed in the following decades. This would almost certainly have resulted in a completely different approach to the provision of safety in the workplace in the United Kingdom. It is also interesting to note that the few requirements in the 1802 Act relating to safety or welfare were omitted entirely from the 1833 Act or greatly reduced in scope. Unlike the 1802 Act, there was no specific requirement for ventilation and the requirement for twice-yearly lime-washing was reduced to annually, and even then the Inspector could give written permission removing the need for it.

Although perhaps more notable for what it did not include rather than what it did, the regulatory approach for the protection of workers’ health and safety could be considered to have its origins in the 1833 Act. The introduction of a government enforcement agency put in place all of the machinery necessary for state regulation of workplace health and safety although the inadequacies of both the 1833 Act and the Inspectorate quickly became apparent. Although the role of the factory inspector was focused on hours of work by children, in his report of 1835 one of the newly appointed Inspectors, Robert Saunders, commented on workplace accidents, noting that there was no provision for their

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88 Thomas, *The Early Factory Legislation. A Study in Legislative and Administrative Evolution* op. cit. n.60, p.226
notification to the Inspectorate.\textsuperscript{90} Perhaps more importantly, he made specific mention of the dangerous state of unguarded machinery, a matter also mentioned by his fellow inspector, T. Jones Howell.\textsuperscript{91}

The general dissatisfaction with the 1833 Act resulted in pressure on the government to review both the scope of the Act and the role of inspectors and their superintendents. A Select Committee chaired by Lord Ashley was established in 1840 to examine the implementation of the 1833 Act, reporting in February, 1841.\textsuperscript{92} The intention of the Committee was not to recommend new legislation but to make recommendations for the improved operation of the existing. On that basis, the Committee focussed on the hours of work by children and young persons, the age of child workers, their education provision, and so on, but it also made recommendations in respect of workplace safety.

Evidence given to the Committee by superintendents told a story of serious injuries and deaths of workers, particularly children, as a result of coming into contact with moving parts of machinery. According to evidence given by one of the superintendents, the verdict of accidental death was invariably the outcome of Coroners’ Inquests held in respect of fatalities arising from workplace accidents, implying that there was no blame attached to employers for these deaths, irrespective of their cause. \textsuperscript{93}

The Committee made four recommendations in respect of worker safety including a prohibition of the cleaning of moving machinery, guarding (or “boxing-off”) dangerous parts of machinery and the payment of compensation where the injury had occurred through contact with dangerous parts of machinery left exposed through negligence. Should an inspector see a dangerous part of a machine, they could give written notice to the mill owner and should a worker subsequently be injured as a consequence of coming into contact with it, the mill owner would be subject to a fine in addition to any

\begin{footnotes}
\item[90] Robert J. Saunders, \textit{Factories regulation. Reports made to the Secretary of State by the Inspectors of Factories, in pursuance of the 45th section of the Factories Regulation Act.} (House of Commons Papers; Reports of Commissioners, 1835)
\item[91] Thomas Jones Howell, \textit{Factories regulation. Reports made to the Secretary of State by the Inspectors of Factories, in pursuance of the 45th section of the Factories Regulation Act.} (House of Commons Papers; Reports of Commissioners, 1835)
\item[92] Anthony Ashley Cooper, 7th E. Shaftesbury, \textit{Report from the Select Committee on the Act for the Regulation of Mills and Factories.} (House of Commons Papers; Reports of Committees Session 1, Paper Number 56, 1841)
\item[93] Ibid
\end{footnotes}
compensation paid out. There were other recommendations that fell outside the scope of the 1833 Act, for example extending the legislation to deal with silk mills and the prohibition of tampering with factory clocks, but the main recommendations represented a radical departure from the previous regulation of factories. It should be noted that although the Committee recommended extending the legislation to cover silk mills, this was still part of the textile industry; all other industries plus a significant part of the textile industry remained outside the scope of the legislation.

A series of bills based on the recommendations of the Committee were presented to Parliament, culminating in the final bill in February 1844. The Bill of 1844 contained most of the recommendations made by the Committee including a prohibition on the cleaning of moving machinery, guarding of certain machinery parts, notice of dangerous machinery to be given by Inspectors to mill owners and the notification of accidents resulting in the injured person being absent from work. The Act came into force in June 1844 and its most significant impact was the requirement to guard certain types of moving machinery and the prohibition on children and young people cleaning machinery which was in motion or working between moving and fixed parts of a self-acting machine when it was mechanically propelled. The penalty for non-compliance was a fine not less than £5 and not more than £20, and if an Inspector was satisfied that machinery was not properly guarded he was required to give written notice to the factory occupier to that effect, set out in the form of a schedule. Giving fourteen days' notice, the occupier could have the matter referred to two arbitrators, one appointed by himself and the other appointed by the Inspector who would determine whether or not there was a failure to comply. Should the two arbitrators disagree, a third arbitrator would be appointed. If it was agreed that guarding was unnecessary or impossible, the notice was to be cancelled.

The requirement for the guarding of dangerous parts of machines was not universally welcomed and the idea that accidents could be caused by anything

94 Thomas, The Early Factory Legislation. A Study in Legislative and Administrative Evolution op. cit. n.60, p.234
95 Factories. A bill for regulating the employment of children, young persons and women in factories, (1844)
96 An Act to amend the Laws relating to Labour in Factories 1844 (7&8 Vict c.15)
other than the carelessness of workers was dismissed by certain parts of society. The 1844 Act was seen as ‘meddling and mischievous’ by many factory owners and there was an effort made to reduce the level of protection afforded by it, if not remove it altogether. The fight to water-down the guarding provisions of the 1844 Act continued and in 1856, a further Act was introduced to clarify where “…Doubts have arisen as to the true Construction of the said several Sections:”, namely the general requirement to guard certain parts of machinery. The 1856 Act restricted the need to guard mill-gearing to those parts that children, young persons and women could come into contact with, thus reducing the level of protection afforded to others who used machinery.

The 1844 Act was much more extensive than the previous acts and included requirements for more serious accidents to be investigated by the certifying surgeon and a report sent to the sub-Inspector of Factories for the area. Certifying surgeons were employed to certify the age of the children employed in the factory and confirm their fitness for the work they were expected to carry out. Fees were paid by the factory occupiers but could be recovered from the wages of the workers examined. An interesting inclusion in the 1844 Act was the ability of the courts to increase the penalty for failing to guard specified machinery where a person had suffered injury as a consequence of that failure. Section 60 of the Act allowed all or part of the increased penalty of between £10 and £100 to be given to the victim at the discretion of the Secretary of State. Any award made tended towards the lower end of the spectrum, with £10 being a typical award with no record of the maximum award of £100 having ever been made. Although Section 60 made reference to “…any bodily injury…”, Bartrip and Burman found that payment was made to the personal representatives of the victims who had been killed as a result of coming into contact with the parts of machinery referred to previously. This seems to contradict Howells who suggested that the lack of any provision for compensation in the event of a fatal injury was an oversight.

97 Harriet Martineau, _The factory controversy: a warning against meddling legislation_ (1855) 44
98 An Act for the further Amendment of the Laws relating to Labour in Factories 1856 (13&14 Vict 54)
99 Howells, ‘Priestley v. Fowler and the Factory Acts’ op. cit. n.52, p.373
100 Ibid; Bartrip and Burman, _The Wounded Soldiers of Industry. Industrial Compensation Policy 1833 - 1897_ op. cit. n.26, p.57
101 Bartrip and Burman, _The Wounded Soldiers of Industry. Industrial Compensation Policy 1833 - 1897_ op. cit. n.26, p57
accident was a weakness of the 1844 Act. Peacock was even more adamant in stating that compensation could not be awarded in the event of death.

The power to make an award for injury caused by unguarded machinery remained in statute until the Employers’ Liability Act of 1880 but after 1862, there seems to be only one such case, where an award was made to the grandmother of a deceased child. Bartrip and Burnam suggested a number of reasons for the failure by the factory inspectors to use Section 60 more extensively including employers volunteering to pay suitable compensation leading to proceedings being abandoned. Howells also pointed out that that some magistrates would abandon any hearing under this section of the Act if notified that compensation had already been paid to the victim. Howells went on to suggest that penal compensation schemes of the type established by 1844 Act were unsuccessful since the sums imposed on employers were insufficient to be any kind of deterrent resulting in neglect being “...the cheapest policy for the entrepreneur to pursue...”. A further provision of the 1844 Act worthy of comment is the requirement for notice to be sent to the certifying surgeon within twenty-four hours of any accident which caused bodily harm resulting in the victim being unable to return to work before 9.00am the following morning. The certifying surgeon was then required to visit the factory as quickly as possible to make a full investigation of the nature and causes of the injury. A report was then to be sent to the district inspector within twenty-four hours.

The 1844 Act was a significant and substantial piece of legislation containing many provisions not discussed here and although it was still only applied to textile mills and factories, worker protection was being extended in other areas of industry. 1842 saw the introduction of an Act to prohibit the employment of Women and Girls in Mines and Collieries; to regulate the employment of

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102 Howells, ‘ Priestley v. Fowler and the Factory Acts’ op. cit. n.52, p.374
103 Peacock, The Successful Prosecution of the Factory Acts, 1833-55’ op. cit. n.87, p.200
104 Bartrip and Burman, The Wounded Soldiers of Industry. Industrial Compensation Policy 1833 - 1897 op. cit. n.26, p59
105 Howells, ‘ Priestley v. Fowler and the Factory Acts’ op. cit. n.52, p.380
106 Ibid
Boys, and to make other provisions relating to persons working therein.\textsuperscript{107} This Act prohibited the employment of women, girls and boys under the age of 10 in mines and restricted the employment of boys under the age of thirteen. It also allowed for the appointment of Inspectors of Mines and Collieries by the Secretary of State. For all its faults, the 1844 Act was an important piece of legislation, not least because it established the pattern of consolidation rather than innovation which characterised the development of the Factories Acts over the following half-century. Legislation was extended to other parts of the textile industry such as print and dye works, lace and rope making but it was not until the 1864 Act for the Extension of the Factory Acts that industries other than textiles came under legislative control.\textsuperscript{108} The Act of 1864 extended some legal protection to workers in a further six specified industries including earthenware (excluding brick and tile manufacture), lucifer matchmaking, percussion cap manufacturing, cartridge manufacturing, paper staining and fustian cutting.\textsuperscript{109} All of these industries were associated with particular hazards to health and safety or were notorious for long hours and the employment of children.

A wider range of industries was brought under legislative control in 1867 but a distinction was drawn between factories and workshops with the introduction of two new Acts.\textsuperscript{110} The Factory Acts Extension Act 1867 extended the scope of the earlier acts to include a range of industries including blast furnaces, copper mills, certain types of mills and forges and factories where power was used for the manufacture of machinery, metal articles and gutta percha, paper, glass or tobacco manufacture, letter-press printing, bookbinding.\textsuperscript{111} It also included any premises where fifty or more persons were employed in any manufacturing process.\textsuperscript{112} There were further specific requirements included in the Act dealing with a range of specified dangerous processes. It is worth noting that this Act did not introduce any additional measures, it only extended those already in

\textsuperscript{107} An Act to Prohibit the Employment of Women and Girls in Mines and Collieries, to Regulate the Employment of Boys, and make Provisions for the Safety of Persons working therein 1842 (5&6 Vict. c.99)
\textsuperscript{108} An Act for the Extension of the Factory Acts 1864 (27 & 28 Vict c38)
\textsuperscript{109} Ibid
\textsuperscript{110} Factory Acts Extension Act 1867 (30 & 31 Vic. c. 103); The Workshop Regulation Act 1867 (30 & 31 Vict c136)
\textsuperscript{111} Factory Acts Extension Act 1867 (30 & 31 Vic. c. 103) S.3
\textsuperscript{112} Ibid
existence to a wider range of industries and activities. The Workshop Regulation Act of 1867 applied to manufacturing premises where fewer than fifty persons were employed (unless already subject to the requirements of the earlier Factory Acts). Workshops included all other premises where the activities associated with manufacturing were undertaken but without the use of mechanical power. There was little difference in the requirements for textile and non-textile factories but the requirements for workshops, particularly in respect of hours of work tended to be much more flexible and this did give rise subsequently to the problems of sweated labour in these types of premises.

Although similar to the Factory Acts, the requirements of the Workshop Act tended to be less onerous. One significant difference was the involvement of local authorities in its enforcement, first proposed by the Children’s Employment Commission in their third report in 1864 as a means of reducing the expense of employing additional factory inspectors to cope with the large increase in numbers of premises covered by the legislation. When introducing the Hours of Labour Regulation Bill to the House of Commons in 1867, Walpole, commenting that it would be impossible to appoint enough factory inspectors to cope with the increased number of premises covered by the legislation, proposed that local authorities would be responsible for its enforcement. The Workshop Regulation Act, 1867 came into force on 21 August 1867 and included the requirement for local authorities to enforce it. Although the proposal to use local authorities originated from the Commission, it was far from enthusiastic about this option stating that it “…would only be with reluctance and as an alternative we should recommend this course to be pursued.”

113 R. W. Cooke-Taylor, Factory system; Factory laws and legislation (Social Questions of Today, Methuen 1894) 99;
114 The Workshop Regulation Act 1867 (30 & 31 Vict c136) preamble
115 Cooke-Taylor, Factory system; Factory laws and legislation op. cit. n.113, p.118; Hutchins and Harrison, History of Factory Legislation op. cit. n.62, p.21
116 Cooke-Taylor, Factory system; Factory laws and legislation op. cit. n.113, p.102; Hutchins and Harrison, History of Factory Legislation op. cit. n.62, p.172
117 Hugh Seymour Tremewan, Children’s Employment Commission (1862). Third report of the commissioners. (Command Papers; Reports of Commissioners XXII, 319, 1864) xx
118 Bill for regulating the Hours of Labour for children, young persons, and women employed in workshops; and for other purposes relating thereto.
119 The Workshop Regulation Act 1867 (30 & 31 Vict c136) 5.18
120 Tremewan, Children's Employment Commission (1862). Third report of the commissioners. op. cit. n.113, p.xxii
legislation would take place just over 100 years later when Robens was taking evidence for his report which led to the Health and Safety at Work etc. Act 1974.\textsuperscript{121}

It was not until the 1878 Factory Act that workshops and factories ceased being subject to separate legislation although the distinction between them remained in place for some time after that.\textsuperscript{122} The 1878 Act was another consolidating provision, bringing together the previous factory and workshop legislation as well as introducing new requirements. The 1878 Act introduced a new way of classifying factories; textile factories and non-textile factories. Although workshops were included in the same Act, they were further separated into three classes, workshops, workshops where neither children nor young persons were employed and domestic workshops. The definition of “factory” was rather complicated which Redgrave interpreted as “…a place in which machinery is moved by the aid of steam, water, or other mechanical power.”\textsuperscript{123} This is slightly different from the interpretation by Hutchins and Harrison who define “factory” as “…premises where any articles are made, altered, repaired, ornamented, finished or adapted for sale by means of manual labour exercised for gain, if \textit{mechanical power is used on the premises}”.\textsuperscript{124} They go on to point out that some of the provisions of the 1878 Act extended to a few specific non-textile factories whether power was used or not. The definition of “factory” contained in the final Factory Act which became law in 1961 was almost identical to that used by Hutchins and Harrison.\textsuperscript{125}

Section 82 of the Act expanded on the explicit offence established in the 1844 Act of causing death or bodily injury through the use of unguarded or inadequately guarded machinery in contravention of the Act, including the concept of penal compensation.\textsuperscript{126} A fine not exceeding £100 could be imposed upon the factory occupier, some or all of which could be applied “for the benefit of the injured person or his family”.\textsuperscript{127} This system of “penal compensation”

\textsuperscript{121} Robens, \textit{Safety and Health at Work. Report of the Committee 1970-72} op. cit. n.20, p.72. \textit{The Robens’ report will be discussed in more detail later in this chapter.}
\textsuperscript{122} Factory and Workshop Act 1878 (41 Vict c16)
\textsuperscript{123} J.A. Redgrave and H.S. Scrivener, \textit{Redgrave’s Factory Acts} (6th edn, Shaw and Sons 1895) xii
\textsuperscript{124} Hutchins and Harrison, \textit{History of Factory Legislation} op. cit. n.62, p.182 Italics in original.
\textsuperscript{125} Graveson, ‘The Movement From Status To Contract’ op. cit. n.37, p.176
\textsuperscript{126} Factory and Workshop Act 1878 (41 Vict c16) S.82
\textsuperscript{127} Ibid S.82
was only ended with the introduction of the Factories Act 1959 although it seemed to fall out of use by the turn of the twentieth century. Howells put this down to the increased success of civil action taken by victims and their families towards the end of the nineteenth and beginning of the twentieth centuries.

The following years saw a number of supplementary Factory Acts, most notably those of 1891 and 1895, which amended the 1878 Act or repealed sections of it. It is fair to say that these acts continued the well-established approach of evolution and consolidation rather than innovation, and whilst they may have had a noticeable impact on specific aspects of work, in themselves they were not significant steps forward in worker protection. Reflecting the well-established approach discussed previously in this Chapter, this period could best be described as one of evolution, rather than revolution, but the system of regulation enforced by a central inspectorate had been well established.

1901 saw a further Factory and Workshop Act which consolidated and repealed the 1878, 1891 and 1895 Acts along with a range of amending instruments introduced over that period. Once again, the 1901 Act did not contain any significant changes to the existing requirements. Protection for women, young persons and children was further enhanced, including the prohibition of the employment of children under the age of 12. Sanitary and health and safety arrangements were enhanced, as were the accident recording and reporting requirements. The distinction between workshops and factories was retained but some additional classes were established including textile factories, non-textile factories, tenement factories and domestic factories. There were even more classes of workshops, namely Workshops, Tenement Workshops, Men’s Workshops, Women’s Workshops and Domestic Workshops.

Perhaps one of the most significant aspects of the 1901 Act was the increased involvement of local authorities and the Medical Officer of Health in the application of the Public Health Act 1875 to factories. As previously discussed, the 1878 Act made local authorities responsible for enforcing parts of the

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129 Factory and Workshop Act 1901 (1 Edw. 7 c.22)
130 Ibid S.149; Bowstead, The Law Relating to Factories and Workshops op. cit. n.52, p.367
legislation dealing with sanitary arrangements and means of escape in the event of fire in workshops but the 1901 Act extended some of these responsibilities to include factories. The Public Health Act of 1875 which dealt with sanitary arrangements and removal of nuisances applied to workshops but not factories and the factory inspectorate had no powers to rectify any nuisances in premises that would fall under its jurisdiction. Instead, where an inspector encountered nuisances in factories, a report had to be made to the local authority who would then take the appropriate action. The 1901 Act included provision for the factory inspector to take over these responsibilities from the local authority if they were not being properly undertaken; moreover, the factory inspector could recover any costs incurred whilst doing so. This power continued in the twentieth century in Section 46 of the Health and Safety at Work etc. Act 1974 which allows the Secretary of State to transfer the enforcement function from a local authority to the Health and Safety Executive if satisfied that the former has failed to carry it out to a satisfactory standard.

Although an improvement in many respects, the 1901 Act still allowed young people to work long hours in difficult conditions. There was some limited protection for agricultural workers and those employed in mines and quarries but the legislation excluded large sections of the working population. As a consolidating Act, the 1901 Act introduced little that was new, which continued to be the case for the next sixty years even with two major Factories Acts being introduced during that time, both of which were consolidating in nature. In addition to the two major acts, there was a large number of statutory instruments in the form of regulations and orders issued mainly to deal with specific industries or activities.

The next major Factories Act was in 1937 which, once again was a consolidating Act. The 1937 Act made no reference to “workshops” but there was still a distinction drawn between factories where mechanical power is used and where it is not. There were no major new developments in the 1937 Act, but the

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131 Factory and Workshop Act 1901 (1 Edw. 7 c.22) S.5
132 Ibid S.4
133 The Health and Safety at Work etc. Act 1974 (c.37) S.46
134 B. L. Hutchins, ‘Gaps in Our Factory Legislation’ (1908) 18 The Economic Journal 221 222
135 Factories Act 1937 (1 Edw 8. & 1 Geo 6. c.67)
requirements for guarding were strengthened.\textsuperscript{136} A new minimum working temperature to be achieved within the first hour of work of 60\textsuperscript{0} F was introduced by section 3(2) of the 1937 Act. Although no longer included in legislation, this temperature (converted to 16\textsuperscript{0} C) has been reproduced in the most recent Approved Code of Practice for the Workplace (Health, Safety and Welfare) Regulations 1992 as a minimum acceptable working temperature.\textsuperscript{137}

The role of local authorities continued in the 1937 Act, with responsibility for the enforcement of sanitary accommodation requirements in all factories. For factories where no mechanical power was used, local authorities also enforced the provisions relating to cleanliness, overcrowding, ventilation, temperature and drainage. The provision of means of escape in case of fire from certain factories also remained with local authorities.

The next major (and final) Factories Act was introduced in 1961 and again was a consolidating Act.\textsuperscript{138} Unlike the previous acts, there doesn’t appear to be any comment or discussion on its content or implementation. A guide was published by the Ministry of Labour to support the legislation but very little else.\textsuperscript{139} The 1961 Act was very similar in most respects to the 1937 Act, including the role of local authorities in the enforcement of certain parts where no mechanical power was used in the factory. Certain sections of the Factories Act 1961 remained in force into the twenty-first century although the main requirements were repealed by the Health and Safety at Work etc. Act 1974.

The history of the Factories Acts shows a sequence of legislative provision focussed on improving working conditions rather than addressing workplace accidents and culpability. As will be discussed in later chapters, this emphasis on improvement rather than punishment certainly contributed to the perceived need for some mechanism to address corporate killing, something that was not catered for in the Factories Acts, nor the Health and Safety at Work etc. Act 1974. The 1974 Act will be discussed in more detail in Chapter Three.

\textsuperscript{136} F. Tillyard, ‘The Factories Act, 1937’ (1938) 1 The Modern Law Review 310 311
\textsuperscript{138} Factories Act 1961 c.34 (9 and 10 Eliz 2)
2.4 Other Sectors of Employment

The conditions in mines were at least as bad as those in the very worst factories and mills, and probably worse in most cases. It was not just the working conditions and hours that were desperate, Scottish miners were only released from serfdom in 1799, something that Duckham traces back to the Scottish Poor Laws of 1579 and 1597 which allowed vagrants to bind themselves for life to colliery owners.\textsuperscript{140} The plight of miners was made worse by the Anent Coalyiers and Salters Act of 1606, which made it an offence to hire coal miners or salters without proper testimonial from their previous masters.\textsuperscript{141} It also allowed masters and owners of coal mines and salt pans to “...to apprehend all vagabounds and sturdie beggers to be put to labour”. As stated previously, serfdom in coal mining continued in Scotland until 1799, and according to Devine, its eventual prohibition by the Colliers and Salters (Scotland) Act 1775 and the Colliers (Scotland) Act 1799 was not through altruism but to address a shortage of miners and colliers and increase the number of workers in that industry.\textsuperscript{142} Although miners in other parts of the United Kingdom were not subject to the serfdom imposed upon Scots miners, working conditions were little better and employment of young children was the norm.

Legislation dealing with mines and collieries was first introduced in the United Kingdom in 1842.\textsuperscript{143} Similar to the early factories legislation, the focus of the first mines and collieries acts was on the restriction of children (under 10 for boys), and women from working in mines but it did not extend to work on the surface of pits. The other main provisions were the prohibition on persons younger than 15 operating steam or other powered hoists intended for raising persons up the mine shaft and the authorisation of the Secretary of State to appoint inspectors. It was not until the Act of 1850 that legislation was enacted appointing inspectors but their role was limited to the inspection of mines.\textsuperscript{144} The 1850 Act was repealed in 1855 by a more robust piece of legislation that

\textsuperscript{140} Baron F. Duckham, ‘Serfdom in Eighteenth Century Scotland’ (1969) 54 History 181 178
\textsuperscript{141} 1606 King James the Sext. Anent Coalyiers and Salters c2
\textsuperscript{142} T.M. Devine, \textit{The Scottish Nation 1700 - 2000} (Allen Lane 1999) 260
\textsuperscript{143} Mines and Collieries Act 1842
\textsuperscript{144} F. Tillyard, \textit{Industrial Law} (A & C Black 1916) 258
introduced a range of “General Rules” for all mines and “Special Rules” for individual mines.\textsuperscript{145} There were seven General Rules which were entirely focussed on safety.\textsuperscript{146} Where the inspector was satisfied that dangerous conditions existed, his report could be exhibited at the mine until the dangerous conditions were rectified and any person could discontinue his service without any penalty. The following decades saw continual repeals and modifications of the legislation but as with the Factories Acts, the process was more evolutionary than revolutionary. The final Mines and Quarries Acts was enacted in 1969 and mainly focussed on extending the 1954 Act to include tips following the Aberfan disaster (discussed later in this Chapter).

There were two other sectors which had explicit health, safety and welfare legislation prior to the Health and Safety at Work etc. Act 1974; offices, shops and railway premises and agriculture. The Shop Hours Regulations Act of 1886 set a maximum number of hours that a person under the age of 18 could work to seventy-four per week, inclusive of breaks for meals and district councils had the power to appoint inspectors for the enforcement of the Act.\textsuperscript{147} The Shops Act, as it became in later versions, was amended and updated throughout the late nineteenth and twentieth centuries, culminating with the Shops Act 1950. During that time, the focus remained on hours of work, prohibition of Sunday trading (with some exemptions) and compulsory half-day holiday each week. By 1950, there was some limited reference to health and welfare but it was restricted to requiring seats for female workers and the provision of sanitary facilities. Its enforcement remained with local authorities, many of whom appointed Shops Inspectors to carry it out. Although the limited health and safety requirements were subsequently replaced by the Offices, Shops and Railway Premises Act 1963 and then the Health and Safety at Work etc. Act 1974, the Shops Act was not entirely repealed until 1994 when Sunday trading restrictions in England and Wales were relaxed.\textsuperscript{148} The 1950 Act became more

\textsuperscript{145} Ibid
\textsuperscript{146} Coal Mines (Inspections) Act 1855 c108
\textsuperscript{147} An Act to Limit the Hours of Labour of Children and Young Persons in Shops 1886 (49&50 Vict C.55)
\textsuperscript{148} G. Holgate, ‘Enforcement, local authorities, the courts and the shops act 1950’ (1984) 10 Local Government Studies 53
controversial in the nineteen-eighties and nineteen-nineties than it had been when first enacted mainly due to the Sunday trading debate.

The Offices, Shops and Railway Premises Act 1963 was similar to the Factories Acts in its scope and intent and extended the legislative provision dealing with worker safety and health to a further eight million people.\textsuperscript{149} It reflected many of the requirements of the Factories Acts such as provision for heating, ventilation, cleanliness, overcrowding, sanitary accommodation, guarding dangerous machinery, and so on.\textsuperscript{150} Enforcement of the 1963 Act rested mainly with local authorities but there were exemptions including premises occupied by them, railway premises (but even then local authorities were responsible for the enforcement of kiosks, shops, etc. within a railway station), and so on. One contentious exemption was premises where only a self-employed person or their close family worked, or where twenty-one hours a week or fewer was worked.\textsuperscript{151} In such cases, the 1963 Act did not apply and this was perceived as a significant failing.\textsuperscript{152} Samuels argued that although the self-employed person might be expected to take care of their own safety and that of their close family, there was no protection for part-time workers or visitors who may have reason to frequent the premises. Other requirements of the 1963 Act included the need for premises to be registered and the posting of an abstract of the Act in a prominent place in the premises or employees to be otherwise made aware of its contents. Certain accidents were to be notified to the enforcing authority but this duty did not extend to illness or disease, whereas the Factories Act 1961 did require specific diseases to be notified.

One of the most significant differences between the Factories Act and the 1963 Act arose where a body corporate was found guilty of an offence which had occurred as the result of the “...consent, connivance of, or is attributable to any neglect on the part of, any director, manager, secretary...”, then that person was also liable for prosecution.\textsuperscript{153} This offence did not appear in the Factories Act 1961 but was reproduced, almost verbatim, in the Health and Safety at Work

\begin{footnotesize}
\begin{itemize}
    \item[150] Offices, Shops and Railway Premises Act 1963 (c.41)
    \item[151] Ibid Sections 2, 3
    \item[152] Samuels, ‘Offices, Shops and Railway Premises Act, 1963’ op. cit. n.149, p.540
    \item[153] Offices, Shops and Railway Premises Act 1963 (c.41), S.65
\end{itemize}
\end{footnotesize}
etc. Act 1974.\textsuperscript{154} This offence will be discussed in more detail in subsequent chapters.

The final sector with legislative control of health and safety prior to 1974 was agriculture. The Agricultural Children Act 1873, which came into force on 1st January 1875, prohibited the employment of children under the age of eight in any agricultural work unless employed by their parents on their own land. Children between the ages of eight and twelve could only be employed if they had certificates showing they had achieved a specified level of attendance at school.\textsuperscript{155}

Although further legislation was introduced dealing with working hours of children, young persons and women, health and safety was not subject to legal controls until 1956, with the introduction of the Agriculture (Safety, Health and Welfare Provisions) Act. A much shorter Act than the Factories Act or the Offices, Shops and Railway Premises Act, the 1956 Act still afforded agricultural workers some degree of protection in respect of health and safety including guarding dangerous machinery, general safety, lifting excessive weights and the provision of sanitary facilities. The 1956 Act also had requirements for the recording and notification of accidents and first aid provision similar to those laid down in the Factories Act.

There was other safety-related legislation, much narrower in scope, dealing with specific types of premises or specific hazards, for example, the Nuclear Installations Act 1965 and the Radioactive Substances Act 1960. These and similar Acts were important but limited to a very few premises and/or activities although they did add to the plethora of legislation associated with worker safety and welfare.

It seemed clear to most people that the state of health and safety legislation by the 1960’s was unsatisfactory, with too many people dying or suffering injury or ill-health as a result of work activities.\textsuperscript{156} In 1967, the Ministry of Labour

\textsuperscript{154} The Health and Safety at Work etc. Act 1974 (c.37) Section 37. See further below.\textsuperscript{155} G. F. Chambers, The Agricultural Children Act, 1873, and the Agricultural Gangs Act, 1867 : with introduction and notes (Knight & Co 1873) 6\textsuperscript{156} Alison Broadhurst, ‘A neo-classical Safety Bill?’ (1973) 5 Industrial and Commercial Training 425; Norman Selwyn, Law of Health and Safety at Work (Butterworths 1982) 3; Charles D. Drake
published a First Consultative Document on the comprehensive reform of health and safety legislation and its enforcement in response to the general dissatisfaction.\(^{157}\) Although three-hundred organisations commented on the proposals to merge the Factories Act and Offices, Shops and Railway Premises Act and extend the scope of the legislation to as many workers as possible, according to Robens “doubts grew” as to whether the approach developing from the consultation would have the desired effects or would just be more of the same.\(^{158}\) In her speech introducing the Employed Persons (Health and Safety) Bill in March 1970, Barbara Castle made reference to the First Consultative Document and concluded “…that we need to get away from the conventional approach; that the mere consolidation and revision of existing legislation is not enough. I have, therefore, decided to set up a small, high-powered body to conduct a general inquiry across the whole field—not merely the Factories Act and O.S.R.P. Act.”\(^{159}\) This resulted in the establishment of the Robens Committee in 1970 to address some of the concerns raised over the outcome of the 1967 consultation and the state of workplace health and safety in general. As a consequence of the Government’s eventual decision to adopt a different approach, Castle’s Bill did not progress beyond its second reading.\(^{160}\)

There was a general consensus that the number of deaths, injuries and illnesses arising from work activities was unacceptable although there had been a significant fall in the fatal accident rate since the first decade of the twentieth century, from 17.5 to an average of 4.5 per 100,000 people employed in the decade 1961 - 1970.\(^ {161}\) The safety record of the UK was better than most of its competitors although perhaps not as good as suggested by Selwyn who held that “…it was generally acknowledged that we had in this country the finest regulatory system of legal controls anywhere in the world,…” .\(^ {162}\) Selwyn then qualified this statement by describing a number of fundamental

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\(^{157}\) Robens, *Safety and Health at Work. Report of the Committee 1970-72* op. cit. n.20, p.188

\(^{158}\) Ibid

\(^{159}\) , *HC Deb 2 March 1970 vol 797 cc44-166* (1970)


\(^{162}\) Selwyn, *Law of Health and Safety at Work* op. cit. n.156, p.3
shortcomings of the UK system, some of which will be discussed in more detail below. It is possible that Selwyn was conflating “finest” with oldest, which would certainly be true. Robens was particularly concerned that there appeared to be no discernible improvement in the fatal accident rate during the preceding ten years which suggested that the country had “...reached some sort of plateau in occupational safety and health performance.”163

As discussed previously, the then-existing legislation tended to focus on specific industries or employment sectors, leaving large groups of the working population outside its scope with estimates of such numbers varying from five million to eight million.164 Drake and Wright and Selwyn were writing after the Act came into force so it is likely that their estimates of “new entrants” were more reliable than Robens. As well as large groups of workers having no legal protection, people other than employees who may be affected by work activities generally fell outside the scope of the law. This exclusion included members of the public, as illustrated by the Brent Cross crane disaster in 1964 where a crane collapsed with its load falling on a coach killing seven passengers and injuring a further thirty-two.165 The report into the accident suggested that there was a case to be made for extending the legislative protection afforded by the Factories Act and related legislation to members of the public although when giving evidence on behalf of the Government, counsel for the Attorney General stated that “the Ministry of Transport take the view that the existing Regulations, which cover the use of cranes and other building operations, although in fact designed primarily for the protection of workmen, do, if strictly observed, give protection to the public”.166 This view was repeated by the Minister of Labour, Raymond Gunter, who in a written response to a question about the Report stated that “The protection afforded to the worker by the Factories Act and Regulations does, however, provide incidental protection to members of the public and we do not think this would be effectively increased by an extension of the Act’s scope or of the powers of Factory Inspectors.”167 It

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163 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.3
164 Ibid; Selwyn, Law of Health and Safety at Work op. cit. n.156, p.4; Drake and Wright, Law of Health and Safety at Work: The New Approach op. cit. n.156, p.39
165 House of Commons, Report of the Investigation of the Crane Accident at Brent Cross, Hendon on 20th June 1964, 1965
166 Ibid
167 , HC Deb 01 December 1966 vol 737 cc149-50W (1966)
would be less than a decade before this approach to public protection was completely overturned.

In 1966 the mining village of Aberfan was engulfed in an avalanche of mine spoil from a tip that had been established over the previous fifty years. One of the worst affected buildings was the primary school, where most of the 144 deaths occurred; 116 children aged between seven and ten and 28 adults died in the disaster.\textsuperscript{168} The Government appointed a Tribunal to investigate the causes of the disaster and make recommendations. The Tribunal, chaired by Lord Justice Sir Herbert Edmund Davies, reported its findings on 3\textsuperscript{rd} August 1967.\textsuperscript{169} Although the main focus of the Tribunal was on establishing what happened, how it happened, who was responsible and what lessons could be learned to prevent it happening again, it also considered the legal issues associated with the accident. One of the recommendations made in the Report was for legislation (in this case The Mines and Quarries Act 1954) to be extended to include “...provision for the safety of the general public...”.\textsuperscript{170} It is notable that although the Tribunal found the National Coal Board entirely responsible for the disaster (it eventually admitted liability), there were no criminal proceedings taken against it or any of its employees.\textsuperscript{171} Its liability extended only to the payment of compensation and a partial share of the costs to remove the tip. The disaster fund raised by public subscription was required to pay a significant portion of the cost of the removal.

Unlike the recommendations made following the Brent Cross crane collapse, the recommendations made by the Tribunal to extend the legislation to cover public safety were eventually included in the Mines and Quarries (Tips) Act 1969. In addition to requiring tips to “...be made and kept secure...”, it allowed local authorities to serve notice on owners of disused tips requiring remedial works to be carried out where the tip was considered unstable and that instability could give rise to danger to members of the public.\textsuperscript{172} Owners had the right of appeal and local authorities could carry out work in default and recover the costs.

\textsuperscript{168} Celia Wells, \textit{Negotiating Tragedy: Law and Disasters} (Sweet and Maxwell 1995) 21
\textsuperscript{169} Lord Justice Sir H. Edmund Davies, \textit{Report of the Tribunal appointed to inquire into the Disaster at Aberfan on October 21st 1966, 1967}
\textsuperscript{170} Ibid
\textsuperscript{171} Iain McLean, ‘On Moles and the Habits of Birds: The Unpolitics of Aberfan’ (1997) 8 Twentieth Century British History 285 287
\textsuperscript{172} Mines and Quarries (Tips) Act 1969 (c.10) Section 14
duties included in this Act were further extended by the Mines and Quarries (Tips) Regulations 1971.

The unacceptable level of fatalities arising from work activities, large sectors of industry falling outside legislative control of health and safety and the lack of legal protection for members of the public were the main drivers for the most significant change to health and safety legislation in more than a century. This change started with the publication of the Robens Report which will be discussed in the next section.

2.5 The Robens Report

The Committee on Safety and Health at Work, chaired by Lord Robens, was appointed by the Secretary of State for Employment and its terms of reference were:–

“To review the provision made for the safety and health of persons in the course of their employment (other than transport workers while directly engaged on transport provisions and who are covered by other provisions) and to consider whether any changes are need in:

(1) the scope or nature of the major relevant enactments, or

(2) the nature and extent of voluntary action concerned with these matters, and

to consider whether any further steps are required to safeguard members of the public from hazards, other than general environmental pollution, arising in connection with activities in industrial and commercial premises and construction sites, and to make recommendations”.

The appointment of Alfred Robens as chairman of the committee was perhaps an unusual choice, given the fact that he was chairman of the National Coal Board at the time of Aberfan disaster. That in itself was not reason to question his appointment but his approach to the disaster was perhaps less sympathetic than

might have been expected and he was personally criticised by the Tribunal.\textsuperscript{174} Given Robens’ experience as Chairman of the National Coal Board immediately after Aberfan, it is perhaps unsurprising that the recommendations of the Report of the Committee include a general antipathy towards criminal prosecution following accidents at work. This particular view of the committee will be discussed in more detail later in this Chapter. The Committee collected a wide range of evidence, including one-hundred and eighty three written submissions from organisations and individuals, meetings with various government departments, field visits with inspectors from many of the inspectorates and overseas visits to the US, Canada, Federal Republic of Germany and Sweden and a number of research reviews.

The Report was submitted to the Secretary of State for Employment on 9\textsuperscript{th} June, 1972 and seemed to have strong government support as demonstrated in a speech to Parliament by the Secretary of State for Employment, the Right Honourable Maurice McMillan “The recommendations are far-reaching and the report will obviously require careful study by all concerned, both inside and outside Government. Nevertheless, the Government are convinced that reform is now a matter of considerable urgency in an area of such great importance to all employees, and it is their intention to take early action towards achieving the broad objectives of the report.”\textsuperscript{175} The reaction to its publication was generally positive although there were some dissenting voices with the Labour Research Department describing it as “…a naive and timid mouse…”.\textsuperscript{176,177}

Robens found a system of statutory health and safety control that, whilst not broken, was certainly dysfunctional. The shortcomings of the system at that time were well known and many of the problems have already been discussed, but to build a proper picture of the situation that Robens was presented with, they need to be revisited. The problems identified by Robens can be loosely

\textsuperscript{175}HC Deb 19 July 1972 vol 841 cc618-24 (1972)
\textsuperscript{177}Labour Research Department, ‘Robens and Safety’ op. cit. n.176, p.194

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categorised into two main groups, legislation and enforcement. The shortcomings of the legislation were well known. Robens was of the opinion that there was too much (nine main groups of statute and five-hundred statutory instruments), too much of it was “unsatisfactory” - unintelligible, complex, prescriptive, obsolescent, too focussed on physical aspects of work rather than working practices, it tended to focus on specific industries or activities meaning that a large part of the working population fell outside statutory control of workplace health and safety. Members of the public and other groups of persons who were not employees were not afforded any protection by the legislation (other than by the Mines and Quarries (Tips) Act 1969 discussed above). Enforcement was piecemeal at best, with seven separate inspectorates (plus local authorities) answering to five different government departments, it was inevitable that a coordinated, coherent response to health and safety issues would be difficult, if not impossible in certain circumstances. Some premises could be visited by a range of different inspectorates, each focussing on different aspects of the work activity whereas some premises would fall completely outside all statutory control. This problem affected every level of enforcement, from the inspectorates all the way through to government departments. Major initiatives were not possible without the support of other departments which meant that the rate of progress was determined by the slowest.

Perhaps surprisingly, given the presence of these serious shortcomings affecting just about every aspect of health and safety regulation, Robens identified one main cause of accidents in the workplace, “…the most important reason for accidents at work is apathy.” Although the problem of “apathy” is referred to a number of times in the report, no evidence is put forward to support the view that it was the main cause of accidents in the workplace. The phrase in Chapter Two of the Report “If, as we believe, the greatest obstacles to better standards of safety and health at work are indifference and apathy…” (author’s italics) would suggest that there was no evidence to support the allegation of apathy as the main cause of accidents, or at least to support the emphasis given to it by

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179 Ibid
180 Ibid
181 Ibid
Robens. This view was supported by Simpson who suggested that the conclusion drawn in the report that most accidents were caused by apathy is “…presented as axiomatic rather than a reasoned conclusion”.\textsuperscript{182}

Nichols and Armstrong, partly blaming Robens’ “homespun psychology” for this approach, questioned the basis for his view of apathy as being the main cause for accidents at work, “Not only does it look suspect theoretically; it is markedly lacking in evidence to back it up”.\textsuperscript{183} They went further in proposing that accidents were, in the main, caused by production rather than apathy, although this view was partly based on the analysis of only 5 accidents in a single workshop.\textsuperscript{184} Broadhurst suggested that ignorance was the underlying cause of “much so-called apathy”.\textsuperscript{185} In a speech to the House of Commons, Neil Kinnock took a different, although equally critical view of Robens’ emphasis on apathy.\textsuperscript{186} He agreed with Robens that apathy was the major cause of accidents in the workplace but he described the Report’s reasons for that apathy as a “facile axiom” and went on to say that “…to suggest that the law is the main cause of apathy is a distortion of reality. It is like saying that the crutch has made the cripple”. In the same debate, Paul Rose also questioned the conclusion drawn by Robens that apathy arising from inadequate law was the main cause of accidents in the workplace, instead proposing that inadequate enforcement was the main issue to address.\textsuperscript{187} Kinnock supported this view with the statement “There is a definite link between the existence of apathy and the absence of stringent, effective and punitive laws”.

Most of the recommendations made by Robens and subsequently implemented by the Health and Safety at Work etc. Act 1974 were predicated on the theory that apathy was the root cause of accidents and ill health in the workplace and that apathy arose as a consequence of too much bad legislation. As previously

\textsuperscript{182} Simpson, ‘Safety and Health at Work: Report of the Robens Committee 1970-72’ op. cit. n.176, p. 198
\textsuperscript{183} T. Nichols and P. Armstrong, Safety or Profit. Industrial Accidents & the Conventional Wisdom (Falling Wall Press 1973) 8; ibid
\textsuperscript{184} Ibid
\textsuperscript{185} Alison Broadhurst, ‘Robens: A missed opportunity?’ (1972) 4 Industrial and Commercial Training 595 596
\textsuperscript{186} , HC Deb 21 May 1973 vol 857 cc62-117 (1973)
\textsuperscript{187} Ibid
discussed, this theory did not meet with unanimous support, but its importance in what followed cannot be exaggerated.

The focus of the recommendations contained in the Report was very much on a shift from the enforcement of legislation by a central inspectorate to self-regulation, with those giving rise to the risks being responsible for their control and management requiring the imposition of new duties on employers and employees. The Report made it clear that “...any idea that standards generally should be rigorously enforced through the extensive use of legal sanctions is one that runs counter to our general philosophy”; Simpson suggested that the then existing inspectorates had never had a rigorous policy of prosecution. It is perhaps surprising that Robens was so explicit in his view that standards should not be rigorously enforced by the use of “legal sanctions”, but it does clearly establish the views of the Committee with regards to the shift towards self-regulation. Having said that, Robens’ enthusiasm for voluntarism was demonstrated in 1951 when as Minister of Labour, he introduced the Industrial Disputes (New Order) to the House of Commons. During that debate, he stated “Our industrial relations system rests on the voluntary principle and it is my hope that the principle and that system will be strengthened...”, clearly demonstrating his preference for voluntarism over regulation. Although Robens did not expand upon the meaning of “...the voluntary principle...” in the context of industrial relations, Kahn-Freund proposed that it meant the end of the use of criminal law to achieve “industrial peace” and an emphasis on “...the autonomous organs of negotiation and arbitration...”.

This understanding of the effectiveness of self-regulation did not go unchallenged. Woolf questioned Robens’ “general philosophy” and suggested that it led to the assumption that “...industry can be no more safe and healthy than voluntary methods of self-regulation will make it”. Woolf proposed that voluntary methods, which had always been available to employers, had proved no more successful in the past than legal regulation. In particular, he was dismissive of the statement made by Robens that “infringements” arise

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188 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.80
190 O. Kahn-Freund, ‘Industrial Disputes Order, 1951’ (1951) 14 The Modern Law Review 467 468
191 Woolf, ‘Robens Report--The Wrong Approach?’ op. cit. n.161, p.89
“...through carelessness, oversight, lack of knowledge or means, inadequate supervision or sheer inefficiency. In such circumstances the process of prosecution and punishment by the criminal courts is largely an irrelevancy”.

Woolf disagreed with this view, arguing that “Proof of a guilty mind is not required against motorists for careless or dangerous driving; why should a different standard apply to careless or dangerous employing?”.

Woolf argued that the hope that voluntary methods would prove more effective was based on two assumptions made by Robens; that culpability has little to do with the creation and existence of workplace hazards and that there is less natural conflict between employers and employees in relation to health and safety than any other matter. Both of these assumptions were, according to Woolf, false and he called for a re-examination of Robens’ whole approach to improving health and safety at work which, needless to say, never happened.

The TUC also expressed some concern about the shift towards self-regulation, suggesting that while action from within industry could reduce accidents, it was not an alternative to “strong safety legislation, strictly enforced”. Unlike other areas of employment law and industrial relations, health and safety has never been subject to collective bargaining. When considering health and safety laws and the social security system in the context of “collective laissez-faire”, Davies and Freedland asked the question “How was one to explain the regulation of these matters by law rather than by collective agreements?” They suggested that the explanation may be historical, with the legislation dealing with health and safety preceding collective bargaining but they then went on to quote Kahn-Freund who proposed that “Standards of health, safety and welfare, or of hours of work of women and juveniles, do not, on the whole, lend themselves well to collective bargaining, and - exceptions apart - they are much better enforced by inspectors than by union representatives.” The exclusion of health and safety from collective bargaining continued to generally be the case until the introduction of various nationalisation acts immediately following

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192 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.82
193 Woolf, ‘Robens Report--The Wrong Approach?’ op. cit. n.161, p.91
194 Ibid
195 Labour Research Department, ‘Robens and Safety’ op. cit. n.176, p.195
196 Paul Davies and Mark Freedland, Labour Legislation and Public Policy (Oxford 1993)
197 Sir Otto Kahn-Freund, ‘Labour Law, Selected Writings (Selected Writings, Stevens Publishing 1978) As cited in Davies and Freedland, op. cit. n.196, p.28
the Second World War, and even though the Health and Safety at Work etc. Act 1974 created a wider role for unions and union representatives than before, it was still limited in scope.\(^{198}\) Even Robens, with all his enthusiasm for voluntarism, made it clear that there “…is no legitimate scope for ‘bargaining’ on safety and health issues…” although the report did emphasise the usefulness of “…constructive discussion, joint inspection and participation in working out solutions.”\(^{199}\) The role of the unions in health and safety will be discussed in more detail later in this Chapter and in Chapter Three, where the 1974 Act will be examined.

Finally, Robens’ preference for voluntary codes over statutory regulation was criticised by Simpson who cast doubt on the suggestion that voluntary codes are easier to understand and more flexible and consequently more likely to be effective.\(^{200}\) Simpson also pointed out that the move away from statutory duties could have a deleterious effect on civil claims for damages taken by injured workers following their breach.

It is much easier to find criticism of the Report’s conclusions and recommendations but there was also some limited support for its general approach to regulation. Howells suggested that setting out basic statutory duties supported by voluntary codes “…could not fail to be creative of better attitudes…”\(^{201}\) although in his summary he does go on to suggest that while Robens’ identification of the weaknesses of the system in place at that time was excellent, its remedies were “less persuasive”.\(^{202}\) Hutter supported Robens’ emphasis on business being responsible for health and safety but she was less enthusiastic about the subsequent suggestion that the “occasional spot check” would be sufficient to ensure it properly met this responsibility.\(^{203}\)

As discussed earlier in this Chapter, legislation without effective enforcement provision is doomed to fail and one of the areas considered to be failing was the

\(^{198}\) The Health and Safety at Work etc. Act 1974 (c.37) S 2(4) - (7)
\(^{199}\) Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.21
\(^{201}\) R. W. L. Howells, ‘The Robens Report’ (1972) 1 Ind Law J 185 188
\(^{202}\) Ibid
\(^{203}\) Bridget M. Hutter, ‘An Inspector Calls: The importance of proactive enforcement in the regulatory context’ (1986) 26 Br J Criminol 114 120
Robens was concerned about the fragmentation of the enforcement provision with seven different inspectorates (plus local authorities), each responsible for specific industries or specific activities across industries. The inspectorates found themselves in five different government departments which, according to Robens, meant that “...obsolescence and inadequacies of many of the existing statutory provisions are in no small part due to the fact that where overlapping responsibilities are involved ‘the need to have wide consultation may mean that all can move forward only at the pace of the slowest’”.

Robens’ answer to this was the establishment of a new body which would be responsible for the administration of the new unified Act. It would be separate, self-contained and have autonomy in its day to day operations. The new body would satisfy all the requirements for responsible and accountable management and have a clear identity, with the person at the top being able to “pronounce authoritatively” on all matters relating to health and safety at work. Organisations associated in any way with health and safety in the workplace would be actively involved in the management of the new body which would reflect the principles of self-regulation and self-inspection. Robens went on to strongly recommend that the body should be an executive, not an advisory board, with active involvement in both technical and management at a policy level.

Importantly, the new Authority, as Robens referred to it, was to be separate from any government department with its own budget and staff but performing its duties under the general policy directive of a government minister (the Secretary of State for Employment was suggested). To all intents and purposes, Robens was proposing the establishment of the new Authority as a QUANGO (quasi-autonomous non-governmental organisation). In response to its concern about the large number of separate inspectorates, the Robens Committee recommended the establishment of a unified inspectorate within the new Authority. This, according to Robens would make better use of support

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205 Ibid
206 Ibid
207 Ibid
208 Ibid
and administration services as well as encouraging the exchange of knowledge and experience between inspectors from the different inspectorates. In accordance with its general philosophy of not rigorously enforcing standards (as discussed previously), Robens stated that the focus of the new inspectorate should explicitly be the provision of advice and assistance.\textsuperscript{209} It also recommended more contact between inspectors and workers and their representatives. Finally, Robens did not make any recommendations about the size of the new inspectorate, instead only considering the resources available at that time as being sufficient for its future role.\textsuperscript{210}

Unsurprisingly, the proposal for a new inspectorate was subject to much discussion. Once again, Woolf was very critical of Robens’ views of the nature and scope of the proposed new inspectorate suggesting that this was a missed opportunity.\textsuperscript{211} He was of the opinion that the Factory Inspectorate had always been far too small to effectively enforce the legislation and felt that Robens could have made a case for a much larger inspectorate. This view was reflected by Neil Kinnock who suggested that the number of inspectors would have to be multiplied by fourfold or fivefold if they were to do the job of issuing improvement and prohibition notices effectively.\textsuperscript{212} Nichols and Armstrong expressed serious concern about the apparent under-manning of the inspectorates, concerns that were obviously not addressed by the Report.\textsuperscript{213} It should be noted that the recommendation to create a unified inspectorate did not meet with unanimous support. Skeet expressed concern about the amalgamation of some of the inspectorates and he recommended that at least the Mines and Quarries Inspectorate, Nuclear Installation Inspectorate and the Alkali and Clean Air Inspectorate should remain independent.\textsuperscript{214} The proposal for the expansion of inspectors’ powers also met with some criticism. Broadhurst described wider powers for inspectors as “…unnecessary as they are
obnoxious”.

In particular, she objected to the proposed powers for inspectors to take any person into premises and especially into private residences.

The continuing role of local authorities as enforcement agencies was considered at some length by Robens. The Committee identified two main criticisms of local authority involvement in health and safety enforcement, poorly qualified or experienced staff in some authorities and inconsistencies in interpretation of the law. Robens concluded that local authorities should continue with their enforcement role but with much more cooperation, support and coordination with the new unified authority. Local authorities would very much be the junior partners in the new system of enforcement, taking their instruction and guidance from the new unified authority. A clear delineation between the activities enforced by the new inspectorate and local authorities was perceived as essential for efficient enforcement but the final decision on any particular premises would rest with the area officer of the new inspectorate. The role of local authorities in the enforcement of health and safety legislation does not seem to have been a significant source of debate amongst contemporary commentators who tended to focus on the existing and proposed inspectorates.

As previously discussed, Robens was not supportive of rigorous enforcement of standards. The report referred to a “…considerable body of opinion…” supporting the view that criminal law sanctions had a very limited role to play in improving health and safety in the workplace. From previous discussion, it can be seen that this view was far from unanimous but it did provide a justification for Robens’ recommendations in respect of the future of sanctions and enforcement. Robens clearly stated that criminal proceedings were inappropriate for the “generality” of health and safety offences and recommended that it be reserved only for offences where an exemplary punishment would be expected and supported by the public. This would mean that criminal proceedings would be instituted only for offences of a flagrant, wilful or reckless nature that either have, or could have, resulted in serious injury. The Report did recommend that penalties in such cases be much higher

217 Ibid
than had previously been the case. Woolf, one of the most vehement critics of Robens’, proposed that “...a prosecution should normally follow the discovery of every breach of the safety and health legislation which involves danger to any person...”, a very different approach from that recommended by Robens.²¹⁸

As an alternative to criminal proceedings for health and safety offences, Robens proposed a system of administrative sanctions, namely Improvement and Prohibition Notices.²¹⁹ These could be served by an inspector without the need to go to the courts. Improvement Notices would be the main sanction available to inspectors and would require the recipient to remedy contraventions within a reasonable period of time. Prohibition Notices would only be served in more serious circumstances and would require the activity, equipment or process to be discontinued. In the case of prohibition notices, there would be the option to come into immediate effect but Robens suggested that this would be the exception rather than the rule and that recipients would have a reasonable period of time to take remedial action. In both cases, the recipient of a notice would have the opportunity to appeal against it but not in the criminal courts. Instead, the already existing Industrial Tribunals could be used to hear appeals against notices.

Once again, Woolf expressed concern in respect of the impact improvement notices would have on the number of prosecutions.²²⁰ He suggested that improvement notices would replace rather than supplement the deterrent procedures as inspectors focussed on maintaining good relationships with employers. Simpson also expressed some concern about the emphasis on administrative sanctions since their effectiveness ultimately relied upon threat of criminal proceedings.²²¹ Howells questioned the effectiveness of prohibition notices and commented on what he perceived as the “complexity” of the different proposed classifications.²²² He also suggested that the notices should remain in force unless complied with or annulled by the tribunal.

²¹⁸ Woolf, ‘Robens Report--The Wrong Approach?’ op. cit. n.161, p.94
²²⁰ Woolf, ‘Robens Report--The Wrong Approach?’ op. cit. n.161, p.94
²²² Howells, ‘The Robens Report’ op. cit. n.201, p.191
Robens considered requests from various bodies for the extension of the licensing systems that already existed.\textsuperscript{223} The Committee rejected these requests on the grounds of effectiveness, cost and the potential for transference of responsibility from those who create the risks to the licensing agency. Instead, Robens recommended that licensing should be used “very selectively” and retained mainly for the control of high risk installations and activities. The rejection of a wider use of licensing met with some criticism from Howells who commented on the “inadequate grounds” for this recommendation.\textsuperscript{224} Other than Howells, the use or otherwise of licensing does not appear to have been subject to much comment.

Robens held the view that worker participation in health and safety matters was essential if self-inspection and self-regulation by individual organisations was to be successful.\textsuperscript{225} Robens also believed the best answer was a statutory duty setting out arrangements for participation by employees. Robens pointed out that the concept of worker participation was not new, legislation requiring consultation with workers or their representatives already existed. The Coal Industry Nationalisation Act 1946 was the first of the major nationalisation acts following the second world war and required the National Coal Board to enter into negotiations with organisations representing substantial numbers of workers employed by the Board with respect to a range of issues, including safety, health and welfare. The emphasis placed on organisations representing workers would suggest that the intention was for trade unions to represent workers in these negotiations. The 1946 Act contains no mention of safety committees or safety representatives.

Subsequent nationalisation acts (Electricity Act 1947, Gas Act 1948, Iron and Steel Act 1949) contained similar provisions requiring relevant boards, councils or corporations to consult with organisations representing a substantial number of employees with respect to health, safety and welfare matters, amongst other things. The duties to consult imposed by the nationalised industries acts suggest an extension of collective bargaining rather than an explicit move to improving health, safety and welfare in these industries. Although the nationalised

\textsuperscript{223} Robens, \textit{Safety and Health at Work. Report of the Committee 1970-72} op. cit. n.20, p.87
\textsuperscript{224} Howells, ‘The Robens Report’ op. cit. n.201, p.191
\textsuperscript{225} Robens, \textit{Safety and Health at Work. Report of the Committee 1970-72} op. cit. n.20, p.21
industries had a duty to consult on issues related to health, safety and welfare
as described above, this obviously only applied to workers in those industries and
as Kinnock said, “The trade union interest at shop floor level is regrettably often
based as the Policy Holder Journal puts it ‘on obtaining good settlements of
injury claims for their members rather than tackling the source of the
injuries’”.226

The recommendation contained in the Report was for a statutory duty on “every
employer” to consult with employees or their representatives in respect of
health and safety in the workplace.227 Robens was keen for flexibility in
approach to be encouraged and did not feel that any particular approach
involving safety representatives or safety committees should be specified but
that guidance, in the form of a code of practice, should be produced. The
guidance would offer model arrangements including advice on safety committees
and safety representatives. Broadhurst applauded Robens preference of safety
representatives over safety committees, the latter being the preference of the
Department of Employment at the time.228 In support of that viewpoint,
Broadhurst made reference to her previous research which suggested that safety
committees were ineffective in many situations.

Although Robens suggested that Improvement Notices could be served where the
statutory duty to consult was not carried out effectively, it was felt that it was
not a duty that could in “any strict sense” be capable of enforcement.229
Simpson found it difficult to accept that the approach recommended by Robens
would be more effective than that proposed in the abandoned Employed Persons
(Health and Safety) Bill 1970 which would have required the appointment of
safety representatives by recognised trade unions where more than 10 people
were employed.230 Safety committees would also be able to be requested where
more than a hundred people were employed.

The recommendation for a statutory duty for employers to consult with
employees or their representatives was broadly welcomed but Howells suggested

226 HC Deb 21 May 1973 vol 857 cc62-117
228 Broadhurst, ‘Robens: A missed opportunity?’ op. cit. n.185, p.597
229 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.23
230 Simpson, Safety and Health at Work: Report of the Robens Committee 1970-72’ op. cit. n.176,
p.195
that it did not go far enough.\textsuperscript{231} He expressed surprise that the inspectorate was not obliged to inform and involve safety representatives during inspections and enforcement. He did acknowledge that Robens’ emphasis on self-regulation could explain this omission.

The findings and recommendations of the Robens Committee were mainly implemented in the Health and Safety at Work etc. Act 1974 and this very important piece of legislation will be discussed in detail in Chapter Three.

2.6 Conclusion

From its very earliest days, health and safety legislation has been regulatory rather than criminal in nature and, perhaps as a consequence, never attracted the same level of interest as other types of legislation even though many thousands of lives have been lost and innumerable people injured or made ill as a result of work activities. The regulatory approach to legislating worker safety has continued into the twentieth and twenty-first century and it seems almost certain to continue into the future. Over the past two-hundred years or so the emphasis of legislation dealing with worker safety and its enforcing authorities has been advice, guidance and support for employers, rather than a punitive criminal law response. Arguments can be made in support of such an approach but it will nearly always be to the benefit of employers when compared to the alternative of criminal prosecution in the event of deaths or injuries arising from work. Whether or not workers and other people affected by work activities benefit from the regulatory approach must be called into question but there is little evidence to conclude one way or the other.

There were a number of milestones in the nineteenth century such as the establishment of an inspectorate (emphasising the regulatory nature of the legislation), the requirement for guarding certain parts of machinery and the application to a wider range of industries and activities but it would be latter part of the twentieth century before all workers in all workplaces would be afforded the protection of the law in respect of their health, safety and welfare.

\textsuperscript{231} Howells, ‘The Robens Report’ op. cit. n.201, p.194
It could have been expected that promotion of the regulation of workplace safety was primarily an altruistic affair, with safety and welfare being the priority. Many of the key figures in the eighteenth and nineteenth centuries discussed in this Chapter were indeed driven by the desire to improve the lot of the workers, but there is a strong argument to be made in support of the private interest theory of regulation where the narrow interests of the regulated are served rather than the public benefit. The private interest theory of regulation, which will be discussed in more detail in a later Chapter, could certainly be applied to the regulation of worker safety and welfare, certainly into the twentieth century.

It is interesting to note that during the period covered in this Chapter, there seems to have been very little debate in respect of an employer’s statutory responsibilities to persons other than employees. This was illustrated by both the Brent Cross Crane collapse in 1964 and the Aberfan disaster in 1966. In these cases, and others, the liability of the employers was restricted to the payment of compensation for those killed and injured. There was no question of prosecution for corporate or gross negligence manslaughter of those considered responsible. Robens’ recommendations included imposing a statutory duty on employers to protect the health and safety of persons other than employees who might be affected by their undertaking.

The next Chapter will consider how the recommendations of the Robens Report were implemented as the Health and Safety at Work etc. Act 1974 and its implications for workers and others who could be affected by work activities. The subsequent development of health and safety regulation will be discussed focussing on its application to deaths associated with work activities and its perceived shortcomings in holding employers responsible for them.
3.0 Health and Safety Regulation Post-Robens

3.1 Introduction

The outcome of the Report of the Robens Committee was the Health and Safety at Work etc. Act 1974, which came into force on 1 April 1975. Most of the recommendations contained in the Robens Report were implemented in the 1974 Act but there were some significant omissions, additions and modifications. At the time, the Act was generally welcomed and, according to Lewis “arguably the most important safety statute ever introduced”. This welcome was not universal, however, Selwyn described it as “…turgid, soporific, and, in parts, about as meaningful as medieval metaphysics”. He was also concerned about the failure of the Act to allow a claim for compensation in the event of a workplace accident or ill-health. He referred to the Act as “…basically a criminal statute…” and went on to suggest that the law of health and safety is in fact an amalgam of “criminal law, civil law and preventative measures”. The nature of health and safety legalisation will be discussed later in this and other Chapters but Selwyn identified what could be described as its schizophrenic character, neither criminal nor regulatory, but a bit of both.

The Act has remained largely intact over the years and although there have been some amendments, the provisions dealing with health and safety in the workplace are mostly unchanged. This does not mean that there haven’t been other major changes to health and safety regulation in the United Kingdom. The increasing influence of Europe in respect of health and safety at work has had a significant impact on the original intentions of Robens and the role of the 1974 Act. Perhaps one of the most important changes over recent years has been the introduction of the Health and Safety (Offences) Act 2008 which could be considered more significant in the field of workplace safety than the Corporate Manslaughter and Corporate Homicide Act 2007 and will be discussed later in this Chapter.

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232 The Health and Safety at Work etc. Act 1974 (c.37)
234 Selwyn, Law of Health and Safety at Work op. cit. n.156, p.5
The importance of the Report of the Robens Committee cannot be overstated. Hutter described it as “…a watershed in thinking about the legal regulation of safety and health”\textsuperscript{235}. It changed how safety in the workplace was controlled by legislation, the extent of the legislative control and how the legislation was enforced, but it also perpetuated the perception that laws dealing with workplace safety were “regulatory”, rather than “criminal”. The distinction between regulation and crime will be discussed in more detail in Chapter Six but it has been fundamental in determining how health and safety contraventions and, in particular, deaths arising from work activities have been perceived by the legal profession and the courts. As will be shown in this Chapter, the Health and Safety at Work etc. Act 1974 focuses on contraventions, rather than the consequences of the contraventions (although they would certainly be taken into account during sentencing). The 1974 Act does not make reference to the severity of the outcome of contraventions, only the contraventions themselves, for example, there is no offence in the Act of causing death or serious injury.

A significant innovation introduced by the 1974 Act was its application to all people at work and those affected by work activities, with the only exemption being domestic servants, who were considered ‘part of the family’. The traditional approach of absolute requirements being imposed on employers was replaced with a range of “General Duties” which were based on outcomes rather than inputs, for example, instead of being required to guard dangerous machinery, employers would be required to ensure the health, safety and welfare of employees, so far as is reasonably practicable.\textsuperscript{236} Employers would be required to identify the risks and then identify and implement the most appropriate control measures, taking all the relevant factors into account. This was a significant change of emphasis from what had gone before and an important component of the self-regulation approach mentioned previously.

As discussed in Chapter Two, health and safety legislation in the UK, from its earliest days, was piecemeal, inconsistent and excluded large sectors of industry, commerce and the general public, from the scope of its protection. Enforcement was through a number of different agencies with varying priorities

\textsuperscript{235} Bridget M. Hutter, 'Regulating Employers and Employees: Health and Safety in the Workplace' (1993) 20 Journal of Law and Society 452 453
\textsuperscript{236} Drake and Wright, Law of Health and Safety at Work: The New Approach op. cit. n.156, p.63
with each being responsible to a different government department. Robens identified these and other failings but came to the conclusion that the biggest barrier to the improvement of the safety and health of workers and others who may be affected by work activities was apathy, from both employers and employees.\textsuperscript{237} This conclusion did not receive universal support but it formed the basis for a different approach to health and safety legislation, where the employer and employee were to take on much more responsibility to ensure a safer place of work for both workers and anyone else who may be affected by work activities.

That different approach forms the basis for self-regulation, one of the keystones of the 1974 Act. In the UK, self-regulation in various guises has been used to control a wide range of activities, including advertising, the media, financial services and a large number of organisations representing the professions.\textsuperscript{238} The term ‘self-regulation’ has caused confusion and there are a number of different approaches to it.\textsuperscript{239} Baggott, describing self-regulation as “...a rather vague and elusive concept...” went on to define it as “…as an institutional arrangement whereby an organization regulates the standards of behaviour of its members”.\textsuperscript{240} In the narrower field of self-regulation in the public interest, he subsequently defined it as “…a range of public interest-oriented regulatory systems which allow the regulated to manage the regulatory process”.\textsuperscript{241} Ogus identified three conditions to be satisfied in the justification of self-regulation, namely market failure, inadequacy or inappropriateness of private laws and where it is a better approach than “conventional public regulation”.

In some respects, the term “self-regulation” in the context of the 1974 Act could be considered misleading, employers and other duty holders are still subject to statutory regulation enforced by various central and local government agencies. What the 1974 Act introduced was a different emphasis for compliance, moving from external agencies ensuring duty holders complied with statutory requirements, to the duty holders themselves being responsible for ensuring

\textsuperscript{237} Robens, \textit{Safety and Health at Work. Report of the Committee 1970-72} op. cit. n.20, p.1
\textsuperscript{238} Anthony Ogus, ‘Rethinking Self-Regulation’ (1995) 15 Oxford J of Legal Studies 97
\textsuperscript{239} Anita Levinson, ‘Self-Regulation and Health and Safety’ (1987) 9 Employee Relations 3 4
\textsuperscript{241} Ibid
It is this responsibility imposed upon duty holders that is referred to as “self-regulation” in this context, and it is this that most closely fits the model of “enforced self-regulation” described by Braithwaite, where an organisation is responsible for developing a set of rules dealing with its own specific issues and requirements.242 The regulator can then accept or require revision to these rules by the organisation. This has resulted in what Levi-Faur described as a “hybrid” system, where organisations are required to identify, assess and manage their risks but this self-regulatory approach is enforced alongside more traditional rule-based requirements by the same regulator using the same enforcement mechanisms.243,244 For health and safety in the UK, the health and safety policy statement, which is a requirement for most employers in terms Section 2(3) of the 1974 Act, would be equivalent of the rules to be produced by organisations, as proposed by Braithwaite. Since the 1974 Act, further health and safety legislation has required employers to produce written risk assessments for a range of different activities and these could also be considered as forms of rules, which could be accepted or rejected by the regulator. If they are inadequate, non-existent or not complied with by the organisation, the regulator can use all of the enforcement mechanisms available to it to ensure compliance.

In effect, what self-regulation did not mean for health and safety was voluntarism. There was no choice over compliance with the legislation, nor was it self-enforcement; the enforcement function was reserved for the new unified agency.245 In the case of health and safety in the UK, self-regulation described the requirement for employers and employees to take a proactive approach to compliance with the legislation on the basis of the prevailing conditions and circumstances of the time and in the context of their activities, but with the Health and Safety Executive being responsible for enforcement, effectively

enforced self-regulation. If self-regulation for the purposes of workplace health and safety is considered in the context of Baggott’s definition in the previous paragraph, it clearly falls under the category of “public interest-oriented regulatory systems” but the actual level of management of the regulatory process by the regulated is limited to ensuring its own compliance with the statutory requirements. For self-regulation to be effective, there would have to be “…acceptance and exercise of appropriate responsibilities at all levels within industry and commerce, accompanied by more management initiative and greater involvement of work people”. Levinson identified three forms of self-regulation in the context of workplace safety: by employers and employees (the form envisaged by Robens), by employers and trade unions (which developed in the UK as a consequence of the Employment Protection Act 1975 which restricted the role of safety representative to “…those appointed by a recognised trade union…” and by management alone. Until the introduction of the Health and Safety (Consultation with Employees) Regulations in 1996, this last form of self-regulation would be the norm for organisations which were non-unionised and where no alternative consultation arrangements were made. The legal basis for worker involvement in workplace health and safety will be discussed later in this Chapter.

Given the number of major accidents with a significant loss of life that occurred since the 1974 Act, it could be argued that the concept of self-regulation has been a failure. In particular, the Herald of Free Enterprise, Clapham Train Crash and Piper Alpha (all of which will be discussed in more detail in a later chapter) occurred as the result of significant management failures. This might lead to the conclusion that while the concept of self-regulation may be attractive to industry and government, its effectiveness in improving workplace health and safety and reducing accidents has not been demonstrated, indeed exactly the opposite would appear to be the case. Hutter pointed out that self-regulation is based on a “…corporate philosophy which regards health and safety as the everyday concern of everyone at work so it involves everyone in regulation and

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247 Levinson, ‘Self-Regulation and Health and Safety’ op. cit. n.239, p.3
248 Ibid
249 The Health and Safety (Consultation with Employees) Regulations 1996, (SI 1996/1513)
emphasises individual responsibility...”\textsuperscript{250} This could be considered an ideal but the accidents referred to previously in this paragraph would indicate that health and safety is not “...the everyday concern of everyone...” and thus casts doubt on the whole edifice of self-regulation. Hutter examined the approach taken by British Railways in the late nineteen-eighties/early nineteen-nineties to self-regulation and although she considered it to be “...one of the better motivated and able companies...”, it still struggled to manage it effectively.\textsuperscript{251} As she pointed out, if a company like British Rail which had a clear commitment to health and safety had serious difficulties in self-regulation, hundreds of other companies, particularly small and medium enterprises with far fewer resources at their command, would find it at least as difficult if not more so. The difficulty for small companies to effectively implement self-regulation was borne out in a (rather limited) survey of welding companies in New Zealand carried out by Walls and Dryson who concluded that “[...self-regulation of small New Zealand enterprises has not been a success”\textsuperscript{252} As Baggott pointed out, self-regulation is rarely introduced as the result of public pressure, indeed the opposite is frequently the case with a demand for tighter state regulation.\textsuperscript{253}

This Chapter will examine the 1974 Act in more detail, and in particular its scope, the enforcement regime it established, offences and penalties, the changes introduced by the Health and Safety (Offences) Act 2008, arguably the most significant piece of specific health and safety legislation since the 1974 Act, and its consequences. The role of the European Union on workplace legislation and its constraints on UK Government policy will be also be considered. The perceived inadequacy of the 1974 Act to effectively punish major corporations following a number of major accidents will be discussed in Chapter Five.

\textsuperscript{250} Hutter, ‘Is Enforced Self-regulation a Form of Risk Taking?: The Case of Railway Health and Safety’ op. cit. n.246, p.381
\textsuperscript{251} Ibid
\textsuperscript{252} C. B. Walls and E. W. Dryson, ‘Failure after 5 years of self-regulation: a health and safety audit of New Zealand engineering companies carrying out welding’ (2002) 52 Occupational Medicine 305 308
\textsuperscript{253} Baggott, ‘Regulatory Reform in Britain: The Changing Face of Self-Regulation’ op. cit. n.240, p.445

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3.2 The Health and Safety at Work etc. Act 1974

The Health and Safety at Work etc. Act 1974 ("the 1974 Act") was given Royal Assent on 31 July 1974 with a commencement date of 1 October 1974 and is still in force today. It applies entirely or in part to England, Wales, Scotland and Northern Ireland, although Northern Ireland has specific arrangements. It implemented most of the recommendations of the Robens Committees and added others. It was published in 4 parts; part 1 dealt with health, safety and welfare arrangements and is of most relevance here, Part 2 established the Employment Medical Advisory Service (EMAS), Part 3 dealt with Building Regulations (now repealed) and Part 4 covered miscellaneous and general matters. Dawson et al described the Act as both a piece of enabling legislation and "In Khan-Freund’s (1972) terms...” a “...species of regulatory legislation” although their interpretation of “enabling” is somewhat different from its general interpretation. In the case of the Health and Safety at Work, etc. Act, 1974 Section 15 allows the Secretary of State to make regulations “...for any of the general purposes of this Part...”. This power has been used extensively to implement various EU directives, as will be discussed later in this Chapter. Section 16 also allows the Health and Safety Commission (now combined with the Health and Safety Executive) to approve codes of practice which gives them a quasi-judicial status; failure to comply with an approved code of practice is not in itself an offence but will be deemed proof that an offence in terms of a related statutory provision has occurred unless the defendant can show that the steps taken to comply with the provision are at least as good as those laid down in the approved code of practice.

The premise of Dawson et al, that the 1974 Act is a form of “regulatory legislation”, is out of step with the statement by Selwyn that it is “...basically a criminal statute with appropriate penalties for breaches...”. There is not necessarily a contradiction between these two statements but they do suggest a

254 Sandra Dawson and others, Safety at work: the limits of self-regulation (Cambridge University Press 1988) 14. She goes on to suggest that as enabling legislation it would encourage employers, employees and others to develop systems and strategies to provide a safe place of work, that is, facilitate self-regulation. A more typical interpretation of “enabling legislation” is given by Brenda Barrett and Richard Howells, Occupational Health and Safety Law (3rd edn, M&E Pitman Publishing 1997) as allowing further detailed arrangements to be made

255 Selwyn, Law of Health and Safety at Work op. cit. n.156, p.5
difference in perception of the nature of the 1974 Act in particular and of health and safety legislation more generally. Taking an historical perspective, it was perhaps inevitable that the 1974 Act would be seen by the courts and enforcement authorities as regulatory rather than criminal. It replaced a number of acts and other statutory instruments that were considered regulatory that view continued with the introduction of the 1974 Act. This very important distinction between regulation and criminal law will be discussed in more detail in Chapter Six.

As stated previously, Part 1 of the 1974 Act contains most of the requirements relevant to health and safety in the workplace and establishes the Health and Safety Commission and Health and Safety Executive, as well as introducing the ‘General Duties’ and making provision for enforcement. The 1974 Act applies to all work and work activities with the exception of domestic servants. There have been some grey areas, for example, its application to police officers, but these have generally been resolved and domestic servants are now the only exempted class of employees of any significance.

The main requirements for employers, the self-employed, employees and others having control over premises are contained in the General Duties which are laid down in Sections 2 to 9 of the Act. Two important concepts form the basis of these general duties, namely “so far as is reasonably practicable” and “risk”. Both terms were relatively unfamiliar when the Act was introduced, certainly so far as health and safety regulation was concerned, but they have gone on to form the basis of the United Kingdom’s legislative approach to workplace safety.

The first appearance of the phrase “reasonably practicable” in United Kingdom legislation would appear to have been in The Coal Mines Act 1911 and since then case law has been relied upon to establish its the meaning with the leading definition of the term being found in Edwards v. National Coal Board where Asquith, L.J. stated “‘Reasonably practicable’ is a narrower term than ‘physically possible’ and seems to me to imply that a computation must be made

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256 The Health and Safety at Work etc. Act 1974 (c.37) S.51
257 When the Act was first introduced, as ‘office-bearers’ the police were not considered ‘employees’ and thus were not covered by Section 2 of the 1974 Act. That changed with the introduction of the Police (Health and Safety) Act 1997 (c.42) which made the Chief Constable the employer of police officers.
258 Coal Mines Act, 1911 (1&2 Geo. 5 c.50) S.108 (3), (8)
by the owner, in which the quantum of risk is placed on one scale and the
sacrifice involved in the measures necessary for averting the risk (whether in
money, time or trouble) is placed in the other; and that if it be shown that there
is a gross disproportion between them - the risk being insignificant in relation to
the sacrifice - the defendants discharge the onus on them. Moreover, this
computation falls to be made by the owner at a point of time anterior to the
accident."

This definition established a number of important concepts in respect of the
term “reasonably practicable”, including making it an explicit requirement for
the person on whom the duty is placed to carry out the assessment prior to any
accident taking place. It also clearly places the responsibility for determining
what is or is not reasonably practicable on that person. There have been a
number of cases since Edwards where the concept of reasonably practicable has
been considered but it is still seen as the leading definition of the term. The
principle of the duty holder being responsible for determining what is
practicable or reasonably practicable has been carried forward to the 1974 Act.
Section 40 of the 1974 Act requires the defendant to prove that “…it was not
practicable or not reasonably practicable to do more than was in fact done to
satisfy the duty or requirement, or that there was no better practicable means
than was in fact used...”. Drake and Wright made it clear that the
prosecution must still prove to “…a high degree of probability...” that a
contravention has occurred or an offence committed. It is then for the
accused to show that everything reasonably practicable had been done to
prevent the contravention or offence occurring, taking into account all of the
circumstances. This is an example of a “reverse burden of proof” where the
defendant must prove that she has taken all reasonably practicable steps, rather
than the prosecution proving that she has not. The question of reverse burden
of proof has arisen from time to time since the commencement of the 1974 Act.
In the case of Davies v. Health and Safety Executive the defendant was found

259 Edwards v. National Coal Board [1949] 1 KB 704 (Court of Appeal) 307
260 V. Howes, ’Duties and liabilities under the Health and Safety at Work Act 1974: a step
forward’ (2009) 38 Industrial Law Journal 306 308
261 The Health and Safety at Work etc. Act 1974 (c.37)
263 A useful discussion on the reverse burden of proof can be found in Meredith Blake and Andrew
guilty of contravening Section 3 of the 1974 Act following the death of a self-employed subcontractor, in that he had not taken all reasonably practicable steps to protect the health and safety of persons other than employees.264 Davies appealed against the conviction on the grounds that the reverse burden of proof contained in Section 40 of the 1974 Act was incompatible with the presumption of innocence enshrined in the Human Rights Act 1998. The appeal was dismissed on the grounds that the infringement of the presumption of innocence contained in Section 40 of the Act was justified and compatible with the Human Rights Act 1988.

“So far as is reasonably practicable” was for many years considered a “...limited defence...” for some health and safety offences, a view confirmed by Lord Nimmo Smith in Williams v Farne Salmon and Trout Ltd.265 This view was brought into question by Latham LJ in R. v. HTM where he stated that “...the phrase ‘so far as is reasonably practicable’ is not a defence” going on to describe it as a qualification of the duty to “ensure” the health and safety of employees.266 The concept of “so far as is reasonably practicable” as a defence is one that is well established and was referred to as such by Hoffman LJ throughout the judgement in R. v Associated Octel267, and by others including Tuckey LJ in Davies v Health and Safety Executive268. In his judgement, Latham LJ made reference to Davies v Health and Safety Executive, in which Tuckey LJ suggested that the phrase “so far as is reasonably practicable” qualifies the duty imposed upon employers (and by implication others with similar duties imposed upon them by the 1974 Act) and the offence is caused by breach of the qualified duty.269 From that, Latham LJ concluded, that “so far as is reasonably practicable” is not a defence but has the purpose “...to absolve employers where their conduct is blameless.”270 Irrespective of whether or not “reasonably practicable” is a defence or a qualification of the duty, concern has been

264 Davies v Health and Safety Executive [2002] EWCA Crim 2949
265 Williams v Farne Salmon and Trout Ltd 1988 SLT 1329
266 R. v. HTM [2006] EWCA Crim 1156
268 Davies v Health and Safety Executive
269 Ibid para. 8
expressed about its fairness to the defendant, for example, Hopkins asked how an employer (or employee) could decide what is reasonable practicable.\textsuperscript{271} It is unlikely that Latham LJ’s judgement will have any real practical implications and most employers will continue to view it as a defence rather than a qualification of their statutory duty.

Although United Kingdom relies upon case law for its interpretation of “reasonably practicable”, an attempt has been made in the Occupational Safety and Health Act, 2004 (enacted by the Australian Victoria Parliament), to describe its characteristics as follows:

“To avoid doubt, for the purposes of this Part and the regulations, regard must be had to the following matters in determining what is (or was at a particular time) reasonably practicable in relation to ensuring health and safety—

(a) the likelihood of the hazard or risk concerned eventuating;

(b) the degree of harm that would result if the hazard or risk eventuated;

(c) what the person concerned knows, or ought reasonably to know, about the hazard or risk and any ways of eliminating or reducing the hazard or risk;

(d) the availability and suitability of ways to eliminate or reduce the hazard or risk;

(e) the cost of eliminating or reducing the hazard or risk.”\textsuperscript{272}

Although not a definition as such, the guidance provided in this piece of legislation on the determination of reasonably practicable makes explicit the factors that would be expected to be taken into account, including foreseeability.

The other significant concept introduced by the 1974 Act was “risk” although its significance was almost certainly not appreciated at the time. The Act does not define risk and it is fair to say that it did not take centre stage as it does in

\textsuperscript{271} Hopkins, ‘Compliance with What?: The Fundamental Regulatory Question’ op. cit. n.9, p.438
\textsuperscript{272} Occupational Health and Safety Act 2004 Act No. 107/2004 (Victoria, Australia) S.20
subsequent statutory provisions dealing with workplace safety. There are many
definitions of health and safety risk, perhaps one of the most common is “…the
likelihood that a hazard will actually cause its adverse effects, together with a
measure of the effect” and hazard is considered as anything that could cause an
adverse effect, normally some kind of loss including harm to human health, 
damage to property or loss of reputation.273 There are various forms of risk
including project, financial, corporate, innovation as well as health and safety
risk. All other forms of risk can have a positive or negative outcome, for
example, investing in the stock market, fixed price tender for a major project,
embarking upon a major corporate restructuring, and for all of these forms or
risk, there can be gain or loss. Health and safety risk is the exception because
there can be no gain. Employers and other duty holders may benefit financially
from not managing the risk, but the activity giving rise to the risk can only result
in loss. To give some indication of the attitude to risk in the early days of the
1974 Act, three textbooks written specifically to analyse and assess its impact
barely mention the concept of risk or its importance in establishing reasonable
practicability.274 From the mid-nineteen-eighties, risk and risk assessment
became the main focus for all aspects of workplace health and safety and this
change in emphasis has been reflected in legislation implemented since that
time.

The general duties contained in Sections 2 – 9 of the 1974 Act were intended to
replace the large number of existing statutory requirements with general
statements defining the responsibilities of employers, employees and others,
irrespective of the industry sector they may be in. Since the commencement of
the Act, Section 5 which deals with certain types of emissions into the
atmosphere has been repealed with the offence being transferred to
environmental protection legislation. Section 2, which could be considered the
most important when it comes to worker safety, places a general duty on
employers to ensure, so far as is reasonably practicable, the health, safety and
welfare of employees.275 This basic duty is extended to ensure work practices

273 Health and Safety Executive, ‘ALARP “at a glance”’ (HSE,
274 Alison Broadhurst, The Health and Safety at Work Act in Practice (Heyden 1978); Selwyn, Law
of Health and Safety at Work op. cit. n.156; Drake and Wright, Law of Health and Safety at
Work: The New Approach op. cit. n.156
275 The Health and Safety at Work etc. Act 1974 (c.37) s.2
that are safe and without risks, including the provision and use of plant and machinery, the handling storage and transportation of articles and substances, the provision of information, instruction, training and supervision, the maintenance of safe places of work and access thereto, and the provision of welfare facilities for people at work.

The risk-based approach to safety was a very important feature of the 1974 Act and caused some concern at the time although it was far from a new approach to workplace safety. The argument in favour of a risk-based approach was that it would be flexible in comparison with the more traditional approach of “absolute requirements” taken by the then existing legislation, and adaptable to changes in both technology and society’s expectations. In effect, it provided a system that would not need to be changed in response to changing circumstances since it was based on outcome, i.e., providing worker safety, rather than input, and could accommodate changes in attitudes and perceptions to safety as well as advances in technology and manufacturing.

In many respects, the traditional prescriptive approach was more straightforward for employers to achieve compliance, with the workplace either satisfying the statutory requirements or not and there was little scope for interpretation. As Drake and Wright put it, “The British on the whole prefer statutes which are proof against the imbecile who required detailed guidance and the charlatan bent upon misunderstanding the law”. The prescriptive nature of the requirements contained in the Factories Acts tended towards minimum standards since every employer was required to comply with them as laid down, resulting in judgements which were not necessarily conducive to worker safety. For example in Nicholls v. Austin (Leyton) Ltd, it was held that guarding of dangerous parts of machinery did not extend to material ejected from it as a consequence of its operation, subsequently causing injury to the operator. This case illustrated the problems of the prescriptive approach that could result in the legislation not affording full protection against injury as a result of the circumstances falling outside the prescribed offence. In some

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276 Broadhurst, The Health and Safety at Work Act in Practice op. cit. n.274, p.6
278 Nicholls v F Austin (Leyton) Ltd [1946] AC 493, 2 All ER 92, 44 LGR 287, 115 LJB 329, 90 Sol Jo 628, 175 LT 5, 62 TL R 320 (House of Lords)
circumstances, employers were presented with a requirement to carry out measures that might not improve worker safety or perhaps even be contrary to providing a safe place of work.

The risk-based approach contained in the 1974 Act focussed on outcome, that is, what is expected to be achieved by the employer (with the qualifying “so far as is reasonably practicable” discussed earlier in this Chapter). By requiring employers to ensure the health and safety of employees (so far as is reasonably practicable), the 1974 Act implies an assessment of the risk and appropriate measures taken to eliminate or reduce it to acceptable levels (safety can be defined as acceptable risk which means danger can be considered the presence of unacceptable risk). Instead of relying upon explicit requirements laid down in statute, employers had to proactively identify all the hazards arising from their activities, assess and analyse the risks associated with these hazards and implement control measures where appropriate. This approach was not universally welcomed; James described the offences under Section 2 of the 1974 as “…vague to the point of opacity”. He goes on to criticise the test of reasonably practicable as “…something of a moving beast given the cost-benefit calculation it incorporates”, a characteristic which has been considered an advantage by other commentators.

3.3 Employee Representation

Section 2 also requires the preparation and maintenance of a written health and safety policy statement (in prescribed circumstances), and the appointment of safety representatives and safety committees, the latter provisions being described by Broadhurst as “…the only sensitive issue…” in the Bill and one that took more than its fair share of Committee time. As originally enacted, Section 2(4) of the Act gave the Secretary of State the power to make regulations for the appointment by recognised trades unions of safety

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279 James, ‘Reforming British Health and Safety Law: a framework for discussion’ op. cit. n.10, p.86
280 A written health and safety policy statement is required where five or more persons are employed at any one time (Employers’ Health and Safety Policy Statements (Exceptions) Regulations 1975 (SI 1975/1584)). See also Osborne v. Bill Taylor of Huyton Ltd [1982] IRLR 17
281 Broadhurst, The Health and Safety at Work Act in Practice op. cit. n.274, p.41
representatives to represent the employees. Sub-section 5 extended this power to include regulations for the election of safety representatives by employees to represent them in any consultation carried out in terms of the Act. This went some way to meet the recommendation by Robens for statutory consultation with employees as discussed in Chapter Two. However the Employment Protection Act 1975 subsequently repealed Section 2(5) meaning that the statutory duty to consult with employees was limited to safety representatives and safety committees appointed by recognised trades unions. This change was the subject of much debate in both Houses of Parliament as the Bill progressed and reflected “...an environment of relatively strong trade union movement, a highly regulated labour market, relatively low unemployment levels...” In introducing his amendment to delete the repeal of Section 2(5) of the 1974 Act, Gowrie stated that amongst all of the contentious issues in the Bill, there was nothing “...which has caused more furious disagreement, resentment or anger on this side”. In responding to the amendment to repeal the deletion, Melchett (Parliamentary Under-Secretary in the Department of Industry) identified a number of reasons why the Government was determined for the repeal of Section 2(5) to go ahead. One of the reasons given was that trade unions were expected to take more responsibility for workplace safety, as proposed by Robens, and this change would reinforce this expectation. Melchett also argued that trade unions were best organised to take on the responsibilities for worker participation and to “...give statutory rights and responsibilities to those who cannot make full use of them...” meaning non-unionised workers, would seriously weaken the provisions. The justifications for the repeal of the Section 2(5) continued with the avoidance of serious industrial relations difficulties if employers were required to undertake consultations other than through ‘normal’ channels. There would be a lack of democratic legitimacy in respect of safety representatives who do not have an organisation to “assist” them in exercising these responsibilities. In any case, there was nothing to prevent existing voluntary arrangements between employers and non-unionised employees.

283 HL Deb 25 September 1975 vol 364 cc463-535 (Hansard 1975) 481
284 Ibid
continuing. Perhaps the most telling part of Melchett’s contribution to the debate was the statement that improving workplace health and safety could best be achieved by placing the responsibility ‘firmly’ on trade unions. Even after Melchett’s defence of the Government’s proposed repeal of Section 2(5), Gowrie’s amendment was passed but it was a pyrrhic victory since its repeal was subsequently included in the Employment Protection Act 1975 and the Government quickly achieved its aims.

Regulations were made by the Secretary of State in terms of Section 2(4) of the 1974 Act, The Safety Representatives and Safety Committees Regulations 1977 which allowed for the appointment of safety representatives by recognised trades unions and outlined their functions. It would be 1996 and the introduction of the Health and Safety (Consultation with Employees) Regulations before Robens’ recommendations in respect of worker participation were fully implemented in statute and only then in response to the EC Council Directive 89/391/EEC which required worker participation.

The effectiveness of worker consultation can be measured in two ways; its impact on accidents and ill-health in the workplace, and the extent of participation by the workforce in consultation, either through safety representatives or safety committees. Unfortunately, there is conflicting evidence for both measures. Reilly et al found that organisations with joint consultative committees for health and safety had a lower accident rate than those without any form of worker consultation. Furthermore, they found that organisations with union appointed safety representatives had slightly fewer accidents than those with non-union safety representatives. In research carried out on behalf of the Health and Safety Executive, Walters et al proposed that “the presence of joint arrangements for worker consultation makes a positive contribution to health and safety performance”. Fenn and Ashby found the opposite when analysing the data collected as part of the 1998 Workplace Employee Relations Survey. Their findings indicated that where there was a

286 David Walters and others, HSE Research Report 363. The role and effectiveness of safety representatives in influencing workplace health and safety. (HSE Books, 2005) 1
higher level of union membership accompanied by safety committees, there was a corresponding increase in accident and illness reported. They put forward a number of possible explanations for this, including employees being more likely to report injury or illness, or higher risk establishments being more likely to be unionised but in any case, it would certainly contradict the findings of Walters et al, and the statements repeated on a regular basis by the Health and Safety Executive.

The DTI analysed the 2004 Workplace Employee Relations Survey to determine the extent of worker representation and the facilities and facility time (the time negotiated with the employer for the union representative to carry out their activities) provided to them.\textsuperscript{288} An attempt was made to quantify the benefit of worker representation in the reduction of accidents and ill health in the workplace. The DTI estimated that the presence of safety representatives reduced the number of accidents each year by between 8000 and 13000, equivalent to a saving for society of between £136 million and £371 million each year.\textsuperscript{289} A different conclusion is drawn in respect of illness in the workplace and the DTI analysis did not suggest anything like the same savings, a reduction of between 3000 and 8000 cases of illness each year with a corresponding saving of between £45 million and £207 million. Many assumptions were made by the DTI in drawing these conclusions and there would seem to be no firm evidence one way or the other that employee representation has any significant impact on safety, positive or negative, in the workplace.

The extent of safety representatives and safety committees in the workplace is another question that is difficult to answer definitively since there is no regulatory mechanism for recording the presence of safety representatives or safety committees in organisations. Worker involvement in workplace safety is far from ubiquitous with the Health and Safety Executive estimating that six out of ten workers are not consulted either directly or indirectly on health and safety matters.\textsuperscript{290} This is despite the fact that consultation is a statutory duty imposed upon employers in terms of the Safety Representatives and Safety

\textsuperscript{289} Ibid
\textsuperscript{290} Health and Safety Commission, \textit{Plans for the Worker Involvement Programme. HSC/05/16} (2005) 1
Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996. Most surveys undertaken since the introduction of the 1977 Regulations would indicate that worker consultation in health and safety matters has steadily diminished. This reduction can be traced back almost to the introduction of the 1977 Regulations. Walters and Gourley found that 17% of workplaces had safety representatives in 1979 compared to 9% in 1987 with penetration being over 90% in large employers but in single figures for the smallest employers. 291 Although a small number of workplaces had safety representatives, most of these were large organisations which meant that in 1987, 75% of employees had access to safety representatives. It is worth noting that the figure of 75% in 1987 is a reduction on the equivalent 1979 figure of 79%. The reduction of both the number of workplaces with safety representatives and the number of workers with access to safety representatives can be at least partly attributed to the decline in manufacturing in the UK with the consequent reduction in the number of union members. Both of these factors continued to influence worker consultation in the nineteen-nineties and beyond.

The Second European Survey on Working Conditions published in 1997 found that 60% of workers in the UK had been consulted during the previous 12 months about changes in their work or working conditions. This does not include workers with access to a safety representative but had not been subject to any consultation during that time and it must be noted that consultation is not limited to workplace health and safety issues, but it does give some indication of the extent of consultation. 292 In 2005, the European Foundation for the Improvement of Living and Working Conditions published the findings of its Fourth Survey showing that in the UK, the number of workers who had been consulted in the previous 12 months about work and working conditions had reduced to just over 52% although it is worth noting that almost 90% of the respondents in the UK considered themselves to be well-informed about work-

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292 Pascal Paoli, Second European Survey on Working Conditions (European Foundation for the Improvement of Living and Working Conditions 2007) 200
based risks. When specifically looking at workplace health and safety consultation by employers with their workforce, the TUC identify a similar pattern with a reduction from 68% in 2006 to 44% in 2008.

There are many reasons for the reduction in consultation in respect of health and safety but there seems little doubt that only around half of the workforce in the UK is currently consulted by their employer. Whilst the effectiveness of employee health and safety consultation in reducing accidents and ill-health in the workplace is open to question, it is now a statutory duty for all employers although one that seems to be ignored by most. The Health and Safety Executive points out “...the limited effectiveness of enforcing consultation where the development of trust and co-operation are essential” but it does discuss the circumstances where prosecution for failure to consult may be appropriate. Previous guidance to inspectors was much more ambivalent in respect of the role of enforcement in ensuring compliance with the two main statutory instruments requiring consultation. The 2007 Worker Consultation and Involvement advice published by the Health and Safety Executive suggested that “There is no requirement to measure worker involvement, or to record findings on Inspection Report Forms”, which while true, does indicate a lack of commitment to achieving effective consultation and involvement. This attitude was perhaps reinforced by the statement that both sets of Regulations were “...principally administrative, as they do not directly involve risk”. Again, this statement is generally correct but it does indicate a lack of enthusiasm on behalf of the Executive to the possible prosecution of employers who fail to consult. Whilst the very low involvement of workers in health and safety consultation cannot entirely be blamed on the Health and Safety Executive attitude towards enforcement, it cannot have helped.

295 Health and Safety Executive, *Topic Pack: Enforcement of consultation Regulations* (Health and Safety Executive 2011) 6
3.4 Scope

Marking a completely new departure in health and safety regulation in this
country and throughout the world, Section 3 of the 1974 Act required
employers and self-employed persons to conduct their undertaking in such a way
that they did not put the health and safety of persons not in their employment
at risk (so far as is reasonably practicable). The term “undertaking” has been
interpreted quite widely and includes providing information and instruction to
another employer’s employees. Self-employed persons also have a duty not to
put their own health and safety at risk although it should be noted that the
Löfstedt Review of health and safety regulation recommended exempting self-
employed persons where their activities would have no impact on other
people. This recommendation was made on the basis that EU legislation does
not generally apply to the self-employed and they were exempted from health
and safety legislation in some other countries. Although recognising that the
burden imposed by health and safety regulation on self-employed was not
particularly significant, Löfstedt suggested that it would reduce the perception
that health and safety legislation was being inappropriately applied. If his
recommendations are ever implemented, it would mean that the 1974 Act would
no longer apply to all people at work or affected by work activities. This would
be a major departure in how the legislative control of health and safety in the
United Kingdom.

Health and safety legislation was extended to include members of the public,
visitors, contractors and sub-contractors who may be affected by the work
activities of an employer and, as will be discussed later in this Chapter, this
section has been frequently used to prosecute large organisations when
individual or corporate manslaughter charges have proved unsuccessful. It is
worth noting that in the early days of the Act, the extent that it applied to non-
employees was not entirely clear and there was some suggestion that persons
other than employees were “...people who were actually engaged in the process,

298 The Health and Safety at Work etc. Act 1974 (c.37) s.3
299 R v Swan Hunter Shipbuilders Ltd and Telemeter Installations Ltd [1982] 1 All ER 264, [1981]
300 Professor Ragnar E Löfstedt, Reclaiming health and safety for all: An independent review of
but were not themselves employees”, a much narrower interpretation than was eventually accepted.\textsuperscript{301} The current interpretation was quickly established and the true extent of this Section of the Act was soon fully appreciated.\textsuperscript{302} There are very few employers, if any, that do not have an association with persons other than employees, and there have been a number of interesting cases arising from its enforcement including one of the leading cases dealing with the interpretation of risk, \textit{R v Board of Trustees of the Science Museum}.\textsuperscript{303} In this case, the duty owed to persons other than employees was discussed at length, and perhaps more importantly, the concept of risk was subject to scrutiny. The Science Museum was prosecuted by the Health and Safety Executive following the discovery of Legionella Pneumophila in the air-conditioning system. Legionella Pneumophila is the bacterium responsible for causing Legionnaire’s Disease when inhaled, and poses a particular risk to individuals susceptible to respiratory illness. The Health and Safety Executive’s case was based on the possibility that persons other than employees were exposed to risk as a consequence of the presence of Legionella Pneumophila in the air-conditioning cooling water. It should be noted that there were no known cases of illness arising out of the presence of the bacterium in the cooling water of the air-conditioning system prior to the Health and Safety Executive inspection. The defence argued (unsuccessfully) that there was no case to answer; no actual risk to the public was proved by the prosecution. The judge in the original case held that the prosecution did not have to prove that any member of the public had inhaled the bacterium or even that it was in the air; it was sufficient to prove that it could have been in the air for a risk to the public to exist. He ascribed the meaning to the word risk of “...a possible source of danger” which is much broader than actual danger, a definition which was supported by the appeal court on dismissing the appeal against conviction. This interpretation of risk has been a point of reference in a number of cases since then, for example, \textit{R v. Chargot Ltd} which will be discussed in more detail in Chapter Six.\textsuperscript{304}

\begin{itemize}
  \item \textsuperscript{301} Broadhurst, \textit{The Health and Safety at Work Act in Practice} op. cit. n.274, p.15
  \item \textsuperscript{302} Lewis, ‘Health and Safety at Work Act 1974’ op. cit. n.10, p.443
  \item \textsuperscript{303} \textit{R. v. Board of Trustees of the Science Museum} [1993] 3 All ER 853, [1993] 1 WLR 1171, [1993] ICR 876 (Court of Appeal)
  \item \textsuperscript{304} \textit{R. v. Chargot Ltd (trading as Contract Services) and others} [2008] UKHL 73 Paragraph 20
\end{itemize}
Controllers of premises have a duty under Section 4 to protect the health and safety of persons who are not their employees but who use non-domestic premises as a place of work or as a place where they may use plant or substances provided for their use there, including ingress and egress.\(^\text{305}\) This Section has been used in respect of common parts or properties where there are no employees but are used a place of work. Section 4 would normally be used where Sections 2 or 3 would not be applicable and it extends the scope of the Act beyond the relationships which form the basis for the other general duties.\(^\text{306}\) It is frequently referred to as the ‘Landlord’s’ general duties since it mainly applies to situations where a landlord, property management company or property owner is the duty holder. It is fair to say that this section is much less commonly used than Sections 2 and 3, a search of the Health and Safety Executive Prosecutions Database revealed only one conviction relating to Section 4 between 1 April 1999 and 14 February 2013.\(^\text{307}\)

In addition to imposing duties on employers, self-employed persons and persons having control of premises, the 1974 Act also imposes duties on employees. Section 7 requires employees to take ‘reasonable’ care of their own health and safety and that of other persons who may be affected by their acts or omissions while at work. Employees are also required to co-operate with their employers or any other persons so far as it is necessary for them to comply with the duties imposed by this Act or other relevant statutory provisions. The concept of employees having duties imposed upon them by safety legislation is nothing new; the Factories Act of 1864 allowed employers to make special rules and regulations governing the behaviour of the workforce in certain areas.\(^\text{308}\) The special rules and regulations were required to be approved by the Secretary of State and the maximum penalty was one pound. Subsequent Factories Acts had more explicit requirements, for example, the 1937 Factories Act prohibited employees from interfering with anything provided for furtherance of health and safety and from doing anything that would endanger their own safety or the safety of others.\(^\text{309}\) They were also required to use anything provided for their

\(^{305}\) The Health and Safety at Work etc. Act 1974 (c.37) Section 4  
\(^{306}\) Drake and Wright, Law of Health and Safety at Work: The New Approach op. cit. n.156, p.88  
\(^{308}\) Factory Acts Extension Act Section 5  
\(^{309}\) Factories Act 1937 (1 Edw 8. & 1 Geo 6. c.67)Section 119
safety or the safety of others which, like the prohibitions referred to previously, was carried over to the 1974 Act but ‘omission’ was included to extend the duties previously imposed upon employees. This means that employees can be prosecuted or otherwise subjected to enforcement action for what they haven’t done as well as what they have done if that omission subsequently put their own health and safety or the health and safety of others at risk.

Whilst enforcement action in terms of the Section 7 is normally associated with the acts or omissions in respect of health and safety of shop-floor or other non-managerial workers in the workplace, it applies to all employees, all the way up to boardroom level.\textsuperscript{310} The prosecution of managers and supervisors in terms of Section 7 of the 1974 Act, other than directors and managers subject to Section 37, is described in the Health and Safety Executive guidance on prosecuting individuals.\textsuperscript{311} In general, the HSE would only expect a prosecution to be taken under this section where employees “...have shown reckless disregard for health and safety, and such disregard has resulted in serious risk”. Directors and managers subject to Section 37 may also be employees, and in such cases, the inspector is required to make a judgement about the most appropriate course of action to take given the circumstances. Section 37 will be discussed in more detail later in this Chapter.

Section 7 of the 1974 Act has not been frequently used. A Freedom of Information request by Hughes revealed that from 2000/2001 to 2011/2012, there was total of 239 prosecutions, resulting in 181 convictions.\textsuperscript{312} Prior to the enactment of the Health and Safety (Offences) Act 2008, the penalty for an offence in terms of Section 7 was a fine not exceeding Level 5 of the Standard Scale although an individual employee could be imprisoned for a small number of other offences, for example, failing to comply with a prohibition notice.\textsuperscript{313} As will be discussed later in this Chapter, the 2008 Act has extended the option of

\textsuperscript{310} Barrett and Howells, \textit{Occupational Health and Safety Law} op. cit. n.254, p.87
\textsuperscript{311} Health and Safety Executive, ‘Prosecuting individuals. OC 130/8 version 2’ (HSE, <http://www.hse.gov.uk/foi/internalops/ocs/100-199/130_8.htm#app2> accessed 10 November 2012 Appendix 1, para.8
\textsuperscript{313} The Health and Safety at Work etc. Act 1974 (c.37) S.33
imprisonment on conviction to a wider range of offences, including failure to comply with Section 7 and the other general duties contained in the 1974 Act.

### 3.5 Enforcement

As discussed in Chapter Two, one of the problems identified by Robens was the number of different enforcement agencies with some responsibility for workplace health and safety. In “...England alone responsibilities for administration and enforcement are divided between five government departments...and seven separate inspectorates.”

The Health and Safety at Work etc. Act 1974 implemented his recommendation through the establishment of the Health and Safety Executive and the Health and Safety Commission as bodies corporate. Sections 10 and 11 of the 1974 Act established the Health and Safety Commission and Health and Safety Executive and their general functions. The Commission was a small body, comprising of a chairman and between 6 and 9 members appointed by the Secretary of State and mainly responsible for defining the strategy for improving health and safety in the workplace. The Executive, comprising of three people appointed by the Commission, one of whom was appointed as Director (with the approval of the Secretary of State) and the other two appointed after consultation with the Director, was mainly responsible for the execution of the Commission’s strategy. The Commission and the Executive were not exactly the ‘unified’ inspectorate that Robens recommended, and it would be more than thirty years before a truly unified authority was established. In 2006, the Health and Safety Commission published a paper recommending the preparation of a consultation document for the merger of the Health and Safety Commission and the Health and Safety Executive. This led to the Legislative Reform (Health and Safety Executive) Order 2008 which abolished both the Executive and Commission and re-established the Executive combining the former functions of both organisations.

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314 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.9
315 The Health and Safety at Work etc. Act 1974 (c.37)
With the establishment of the Health and Safety Executive, inspectors from the various inspectorates that existed prior to the 1974 Act were transferred to it with the exception of the agricultural inspectorate. Agriculture was considered a special case and Sections 29 to 32 of the 1974 Act made special arrangements for that sector of industry but the Employment Protection Act of 1975 repealed those sections and the agricultural inspectorate joined the Health and Safety Executive shortly thereafter.\(^{317}\) Local authorities retained their role in health and safety enforcement, mainly in the low risk, service sector but remained very much the junior partner, taking instruction from the Health and Safety Executive in a range of different aspects of enforcement. To clarify the extent of local authority responsibilities and to avoid inspection of a single premises by multiple agencies, regulations were made identifying the premises that local authorities would enforce.\(^{318}\) These regulations were amended over the years.

Although a ‘unified’ inspectorate was established by the 1974 Act, there were some areas of inspection that fell outside its general area of responsibility, for example, offshore safety. The 1974 Act was initially restricted to Great Britain but Section 84 allowed for its provisions to be extended beyond its territorial limits by Order in Council. It was subsequently extended to include workers and others working or associated with the offshore oil and gas industry by the Health and Safety at Work, etc., Act 1974 (Application outside Great Britain) Order 1977 which came into force on 1 September 1977 and extended the main provisions of Parts I and II to offshore installations and pipelines within waters designated by the Continental Shelf Act 1964. Section 13 of the 1974 Act allowed the Commission to enter into what were, in effect, agency agreements with any government department or other persons to perform any of its functions and accordingly enforcement of the 1974 Act in offshore oil and gas exploration and production, although the subject of major debate, was eventually transferred to the Petroleum Engineering Division of the Department of Energy which would report to the Secretary of State for Employment through the HSC and HSE.\(^{319}\) This decision to place responsibility for enforcement of safety legislation in the same government department responsible for production

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\(^{317}\) Broadhurst, *The Health and Safety at Work Act in Practice*, op. cit. n.274, p.59  
\(^{318}\) Health and Safety (Enforcing Authority) Regulations 1977 (S.I. 1977/746)  
received considerable criticism at the time.\(^{320}\) It was only the Piper Alpha disaster in 1988 that convinced government of the importance of a completely independent inspectorate for safety for the offshore industry and the responsibility for offshore safety was transferred to the Health and Safety Executive.

Another significant area where the Health and Safety Executive did not have enforcement responsibility was the railways. An agency agreement drawn up between the Health and Safety Commission and the Secretary of State for Employment transferred that function to the Railway Inspectorate which had been responsible for safety on the railways since the mid-nineteenth century.\(^{321}\) Following the King’s Cross Fire and the Clapham Train Crash, in 1990 the responsibility for railway safety was transferred to the Health and Safety Executive with Her Majesties Railway Inspectorate becoming the division of Railway Safety within the HSE.\(^{322}\) The Railway Inspectorate was subsequently transferred to the Office of Rail Regulation on 1 April 2006. Section 2 of the Railways Act 2005 makes the Office of Rail Regulation the enforcing authority for part 1 of the 1974 Act in respect of railways, tramways and fixed guidance transport systems (although there are exceptions). The Office of Rail Regulation is not an agency of the HSC but the HSE and Office of Rail Regulation are expected to cooperate and coordinate their activities.\(^{323}\)

Since its establishment, the number of front-line staff employed by the Health and Safety Executive has been criticised as being too few to effectively enforce the Act.\(^{324}\) It is difficult to carry out a direct comparison of the numbers of field operatives in the Health and Safety Executive since its establishment following the 1974 Act due to changes in its enforcement responsibilities, but since railways safety was transferred to the Office of Rail Regulation, it has remained a fairly stable organisation. In 2009, there were 1415 front-line inspectors, increasing to 1464 in 2010 but then falling back to 1422 in 2011 and 1388 in


\(^{321}\) D. Fennell, *Investigation into the King’s Cross Underground Fire*, 1988) 145

\(^{322}\) W. Callaghan, *A Farewell to Trains* (Health and Safety Commission 2006) 2

\(^{323}\) Health and Safety Executive/Office of Rail Regulation, *Memorandum of Understanding Between Health and Safety Executive (HSE) and Office of Rail Regulation (ORR)* (2006) 6

\(^{324}\) James, ‘Reforming British Health and Safety Law: a framework for discussion’ op. cit. n.10, p.97
2012.\textsuperscript{325} This timescale is too short to draw any conclusions, but it appears there is a pattern emerging of a loss of front-line staff.

The role of local authorities in health and safety is laid out in the Health and Safety (Enforcement Authority) Regulations.\textsuperscript{326} The controversy over their involvement in health and safety enforcement continued after the 1974 Act came into force and the Löfstedt Review was heavily critical of the role of local authorities in health and safety enforcement, suggesting, amongst other alleged shortcomings, that too many routine inspections were made of ‘low risk’ premises.\textsuperscript{327} This conclusion seemed to be based on the fact that local authorities inspect many more premises that the Health and Safety Executive, even though they tend to be responsible for lower risk premises. Local authorities routinely inspect premises with a lower risk than those enforced by the Health and Safety Executive which are not subject to routine inspection. The fact that many of the health and safety inspections undertaken by local authority inspectors are carried out at the same time as other statutory duties such as food hygiene inspections, is not discussed by Löfstedt even though it must be considered a good use of resources to undertake both at the same time. There is also an assumption that fewer inspections, irrespective of risk level, is the best approach.

While the Health and Safety (Enforcing Authority) Regulations make local authorities responsible for the enforcement in certain premises and the 1974 Act also includes default powers should a local authority fail to perform its enforcement functions, they have been given wide discretion in exactly how they will carry out those functions.\textsuperscript{328} One of the recommendations of the Löfstedt Review is the removal of that discretion and the Health and Safety Executive to be given the authority to direct all health and safety enforcement and inspection activities.\textsuperscript{329} The intention is for the Health and Safety Executive

\textsuperscript{325} Health and Safety Executive, \textit{The Health and Safety Executive\textbackslash Annual Report and Accounts 2009/10. HC20} (The Stationary Office 2010) 30; Health and Safety Executive, \textit{The Health and Safety Executive Annual Report and Accounts 2011/12. HC204} (The Stationary Office 2012) 49

\textsuperscript{326} Health and Safety (Enforcing Authority) Regulations 1998. (SI 1998/494)

\textsuperscript{327} Löfstedt, \textit{Reclaiming health and safety for all: An independent review of health and safety legislation. Cm 8129} op. cit. n.300, p.82

\textsuperscript{328} The Health and Safety at Work etc. Act 1974 (c.37) Section 45

\textsuperscript{329} Löfstedt, \textit{Reclaiming health and safety for all: An independent review of health and safety legislation. Cm 8129} op. cit. n.300, p.85
to direct health and safety enforcement to only the highest risk premises in order to ensure a “...more consistent, targeted and proportionate approach to enforcement”.  

The general attitude of the Health and Safety Executive towards health and safety in the workplace is one of guidance, advice and persuasion, which reflects the spirit of the Robens Report, “...the new inspectorate should be geared to an explicit policy which has as its prime objective the prevention of accidents and ill-health and the promotion of progressively better standards at work through the provision of information and skilled advice...” and “...criminal proceedings are inappropriate for the generality of offences...”.  

It is fair to say that the Health and Safety Executive are continuing the approach taken by the factory inspectorates from their earliest days, including a reluctance to prosecute. This preference for informal action has met with some criticism over the years, for example, Tombs described it as “...more an article of faith than an empirically defensible approach to enforcement”. James and Walters suggested that too much emphasis was placed on the provision of advice and other informal action and a more rigorous enforcement policy should be adopted. Clayton suggested that the wearing of “two hats”, adviser and enforcer, resulted in confusion for inspectors and ambiguity and tension in their relationship with duty holders meaning that neither duty was carried out to the optimum. The reduction of front-line staff discussed previously in this Chapter and the de-regulatory nature of government in the United Kingdom will make any increased focus on enforcement unlikely in the foreseeable future.

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331 Robens, *Safety and Health at Work. Report of the Committee 1970-72* op. cit. n.20, p.67, 82; ibid
332 James, ‘Reforming British Health and Safety Law: a framework for discussion’ op. cit. n.10, p.99
334 Phil James and David Walters, *Regulating Health and Safety at Work: An Agenda for Change?* (The Institute of Employment Rights 2005) 88
335 Clayton, ‘Regulating Occupational Health and Safety: the need for a new paradigm.’ op. cit. n.282, p.9
3.6 Sanctions and Offences

Prior to the 1974 Act, contraventions of workplace health and safety legislation were mainly dealt with informally or by prosecution. Robens was keen to offer a range of alternatives, described as “administrative sanctions”, in the event of a suspected offence or contravention. The 1974 Act introduced Improvement and Prohibition Notices as alternatives to informal action and prosecution.

Where an inspector is satisfied that one or more of the relevant statutory provisions is being contravened or has been contravened in circumstances which make it likely that the contravention will continue or be repeated, then an Improvement Notice may be served in terms of Section 21 of the Act. The notice is served on the person responsible for the contravention and requires the contravention to be remedied within a specified period of time. A Prohibition Notice may be served where an inspector is of the opinion that activities involving risk of serious personal injury are taking place or about to take place. As the name would suggest, a Prohibition Notice prevents the activities being carried on until the matters giving rise to the risk are remedied. It is worth noting that there need not be a contravention of any of the relevant statutory provisions, there need only be the risk of serious personal injury. The recipient of an Improvement or Prohibition Notice has the right of appeal within 21 days of its receipt. The appeal is made to the Industrial Tribunal which may affirm with or without amendments, or dismiss the notice. Improvement Notices will be suspended until the appeal is dealt with but Prohibition Notices will remain in force unless the appellant makes an application to the Tribunal and it so directs. Failure to comply with an Improvement or Prohibition Notice is an offence. As James noted, the introduction of improvement and prohibition notices led to an increase in formal enforcement action but a reduction in the number of prosecutions.

Section 33 of the 1974 Act lists the offences and penalties, some of which are triable only summarily but most are triable either way. Prior to the Health and Safety (Offences) Act 2008, the maximum penalty for most offences tried

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337 The Health and Safety at Work etc. Act 1974 (c.37) Sections 21, 22
338 James, ‘Reforming British Health and Safety Law: a framework for discussion’ op. cit. n.10, p.100
summarily was a fine not exceeding Level 5, and for offences tried on indictment, the penalty was a fine. A limited number of offences, mainly relating to licensing and breach of prohibition notices could also attract a prison sentence of up to two years for conviction on indictment. The current record fine for breach of health and safety legislation is £15 million, made against Transco in respect of a gas explosion in Lanarkshire in 1999 that killed a family of four. 339 Charges of culpable homicide (ultimately unsuccessful) were also brought against Transco and the failure of these charges certainly contributed to the demand for a different approach to death arising from the activities of organisations. 340 Other large fines in respect of health and safety offences includes £10 million (reduced on appeal to £7.5 million) made against Balfour Beatty Rail Infrastructure Ltd following the train crash at Hatfield in 2000, resulting in 4 deaths and a 102 injured. 341 Fines of this level were very much the exception rather than the rule and the range of penalties available for health and safety offences was still somewhat limited.

In many respects, the penalties provided by the 1974 Act are a reflection of its origins, both the regulatory approach that can be traced back to the very earliest days of health and safety legislation but, perhaps more importantly, the recommendations of the Robens Committee with its emphasis on self-regulation with the inspection agencies focussing on providing advice and assistance to employers, employees and others. That, combined with the regulatory nature of the legislation where offences have traditionally been considered less harmful than other types of criminal activity, resulted in a situation where they were punished less severely than their consequences would otherwise suggest. A more punitive approach to health and safety offences was called for resulting in the Health and Safety (Offences) Act 2008.

339 R. v Transco plc [2006] EWCA Crim 838
340 Transco Plc v HM Advocate (No.1) [2004] JC 29; 2004 SLT 41; 2004 SCCR 1; [2005] BCC 296; 2003 GWD 38-1039 (High Court of Justiciary)
341 R. v Balfour Beatty Rail Infrastructure Services Ltd op. cit. n.17
3.7 Health and Safety (Offences) Act 2008

The introduction of the 2008 Act could be considered the most significant change in health and safety legislation since 1974 although its impact has perhaps not been fully appreciated by organisations, their directors and executives. With a wider range of penalties, particularly custodial sentences for various offences committed by individuals including company directors and executives, it has provided the opportunity for a more punitive approach to health and safety offences than previously existed. The increasing use of custodial sentences for health and safety offences, in addition to being more punitive in itself, will begin to blur that rather artificial distinction between regulation and other forms of criminal law. It can be assumed that the stigma of a prison sentence is not diminished as a consequence of it being imposed for a regulatory, rather than criminal offence.

The 2008 Act has its origins in a private member’s bill sponsored by Keith Hill MP in 2007. Hill identified 3 main reasons for the proposed changes; more effective punishment, better deterrence and improved efficiency by allowing more cases to be settled in lower courts due to the availability of a wider range of penalties. The Bill received broad support in both the Commons and the Lords and became law on 16 October 2008, coming into force on 16 January 2009. The Health and Safety (Offences) Act 2008 is a very short piece of legislation which has the single purpose of extending the penalties available for contraventions of the Health and Safety at Work etc. Act 1974. The 2008 Act significantly increases and extends the penalties available for health and safety offences, providing imprisonment for a wider range, whether tried summarily or on indictment. For most offences tried summarily, the maximum penalty can include a prison sentence not exceeding twelve months and/or a fine not exceeding £20000; for most offences tried on indictment, the maximum penalty can include a prison sentence not exceeding two years and/or a fine. The Minister for the Department of Work and Pensions, Lord McKenzie welcomed the Act commenting that it “...will ensure that sentences can now be more easily set at a level to deter businesses that do not take their health and safety management

responsibilities seriously and further encourage employers and others to comply with the law.”

In itself, the 2008 Act is straightforward and has not generated significant comment (although Barrett expressed some disappointment that a more radical review of Section 33 of the 1974 Act which creates health and safety offences had not been undertaken), and certainly very little controversy. The very significant implications for company directors and senior executives become apparent when Section 37 of the 1974 Act is considered. Section 37 states that if it can be shown that an offence in terms of any of the relevant statutory provisions has been committed by a body corporate with the consent, connivance or negligence of a director, manager, secretary or other similar officer, that person will also be guilty of an offence and liable to be prosecuted. The 2008 Act allows such offences to be punished by up to two years imprisonment but it must be stressed that there is no liability on a director, etc. in terms of Section 37 unless the body corporate is guilty of an offence in terms of any of the relevant statutory provisions although it is possible that Section 7 of the 1974 Act could still apply where the body corporate is not guilty of an offence.

The terms ‘consent’, ‘connivance’ and ‘negligence’ have appeared in health and safety legislation since the nineteenth century and have been subject to much discussion and debate, particularly ‘negligence’. Bergman et al defined ‘consent’ as requiring a person to be aware that an offence is taking place and agreeing to it, and ‘connivance’ as the “...turning of a blind eye, rather than agreement”. Both consent and connivance must include an element of mens rea, which negligence does not. Negligence is more difficult to define than consent and connivance and can come in various forms. It is also more

345 B. Barrett, ‘Liability for Safety Offences: Is the Law Still Fatally Flawed?’ (2008) 37 Ind Law J 100; Wright, ‘Criminal liability of directors and senior managers for deaths at work’ op. cit. n.3, p.4
346 David Bergman, Dr Courtney Davis and Bethan Rigby, International comparison of health and safety responsibilities of company directors. RR535 (Prepared by Centre for Corporate Accountability for the Health and Safety Executive, 2007) 5
347 G. Williams, Textbook of Criminal Law (Second edn, Stevens 1983) 95
important in the context of health and safety offences, as will be discussed in a
later chapter. Williams defined negligence as a “...failure to conform to the
standard of care to which it is the defendant's duty to conform”. In citing an
unpublished transcript by Mackay, J., Bergman et al listed five circumstances
that must be present for neglect to exist including the commission of an offence;
the defendant should have known of the facts resulting in the offence; the
defendant had a duty to act in respect of those facts; he neglected to take the
reasonably practicable steps that should have been taken to prevent the offence
occurring (he ‘shut his eyes’); the breach could be attributed to that neglect.
The distinction between ‘negligence’ and ‘gross negligence’ will be discussed in
a later chapter.

One of the first cases taken in terms of Section 37 of the 1974 Act and one of the
first to be tried on indictment for an offence in terms of the 1974 Act was
Armour v. Skeen. This case related to the death of a worker who fell from a
suspended scaffold whilst working on a bridge under repair. The employer was
Strathclyde Regional Council and the Director of Roads was John Armour.
Armour was prosecuted in terms of Section 2 for failing to issue a statement of
health and safety policy applicable to the Roads Department. In this case, it
was held that the failure to comply with the legislation was attributable to
Armour’s neglect. Armour was found guilty and subsequently appealed
unsuccessfully against the judgement. At the time of the offence, the maximum
fine for an offence tried summarily (as in this case), was £400, with an unlimited
fine where the case was taken on indictment. There was no possibility of
imprisonment. As discussed above, with the changes introduced by the 2008
Act, company directors, executives, etc. found guilty in similar circumstances
could now face up to two years imprisonment, in addition to, or as well as a
fine. Between 1999/2000 and 2010/11, 282 prosecutions were taken against
directors, etc. in terms of Section 37 of the Act with 187 resulting in
convictions. It should be noted that these statistics do not include directors,

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348 Ibid
349 Bergman, Davis and Rigby, International comparison of health and safety responsibilities of company directors. RRS35 op. cit. n.346, p.4
350 Armour (John) v Skeen [1977] IRLR 310
etc. who have been prosecuted for workplace deaths arising from gross negligence manslaughter although there were very few such prosecutions over the period in question.

Although there is no record of it having ever happened, Barrett suggested that Section 37 of the 1974 Act could be used to prosecute a whole board of directors, rather than one individual as in Armour. With the introduction of the Health and Safety (Offences) Act 2008, this could mean that a board of directors could face imprisonment should their collective consent, connivance or negligence be held responsible for a health and safety offence, whether or not it resulted in a death arising from work activities. The Health and Safety (Offences) Act 2008 is still a relatively untested piece of legislation and it is too soon to make a judgement on its effectiveness but with its introduction of more readily available prison sentences for a wider range of offences, it does have the potential to change how individual company directors view compliance with health and safety legislation. This potential is sufficient in itself for the 2008 Act to be considered more significant in improving workplace safety than the Corporate Manslaughter and Corporate Homicide Act 2007 particularly since it is applicable to all offences, not just causing death at work.

### 3.8 The European Union, Deregulation and Health and Safety in the UK

It is impossible to discuss health and safety regulation in the UK in the twenty-first century without reference to the influence of the European Union. Since the introduction of the Control of Substances Hazardous to Health Regulations in 1988, very few relevant health and safety statutory provisions have been introduced in the UK that did not have their origins in the European Union. As a consequence, the scope of the UK Government to amend, repeal or modify them has been greatly curtailed. The involvement of the European Union in health and safety in the workplace can be traced back to its earliest days with the

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352 Barrett, 'The Health and Safety (Offences) Act 2008: the cost of behaving dangerously in the workplace' op. cit. n.344, p.4
original Treaty that established the European Coal and Steel Community.\textsuperscript{353} Article 3 of that Treaty required the promotion of the “...improvement of the living and working conditions of the labor force in each of the industries under its jurisdiction so as to make possible the equalization of such conditions in an upward direction”. Article 117 of the Treaty establishing the European Economic Community (EEC) reiterated Article 3 of the 1951 Treaty, and Article 118 (subsequently replaced by Article 137) of the 1957 Treaty (‘The Treaty of Rome’) promoted close collaboration between members in a number of fields, including “protection against occupational accidents and disease” and “industrial hygiene”.\textsuperscript{354} However, as James pointed out, there was no specific mechanism in place to make legislation in respect of these issues.\textsuperscript{355}

The Single European Act, which was intended to establish a single market by 1992, introduced a number of changes to the Treaty of Rome, including a new Article 118A (subsequently replaced by Article 138) which effectively restated the commitment to improve the working environment in respect of health and safety but, importantly, it also provided the Commission with the power to adopt directives to achieve that end.\textsuperscript{356} Article 100A, the other main instrument dealing with safety related issues, requires the application of ‘essential safety requirements’ for products sold within the European Union and is intended to remove barriers to trade on the basis of health and safety.\textsuperscript{357} Article 100A directives are based on a high level of safety rather than the minimum safety requirements typically required by Article 118A directives. Article 118A directives were subject to qualified majority voting which means that unanimity was not required for them to be adopted. This has led to conflict between the European Union and the UK government, particularly in respect of working time.\textsuperscript{358} Directives made under Article 118A are based on minimum requirements and member states can apply higher standards, unlike Article 100A

\footnotesize{\textsuperscript{353} European Coal and Steel Community, \textit{Treaty constituting the European Coal and Steel Community}, 1951
\textsuperscript{354} European Economic Community, \textit{The Treaty establishing the European Economic Community (EEC)}, 1957
\textsuperscript{355} P. James, \textit{The European Community. A Positive Force for UK Health and Safety Law?} (Co-operative Press 1993) 2
\textsuperscript{356} Single European Act 1986
\textsuperscript{357} Erika M. Szyszczak, ‘The working environment v internal market’ (1999) 24 European Law Review 195 197
\textsuperscript{358} B. Fitzpatrick, ‘Straining the Definition of Health and Safety’ (1997) 26 Industrial Law Journal 115}
directives where member states cannot apply standards higher than those laid down in the directive, on the basis that higher standards than those laid down in Article 118A will not be a barrier to the free movement of goods, articles, services or people although it does mean different standards of worker safety across the Union. Member states implement directives using their own legal and governmental framework, with some member states using criminal law to deal with certain regulatory matters whilst others use social insurance mechanisms to achieve their aims and objectives. The UK takes the former approach with Section 15 of the Health and Safety at Work etc. Act 1974 being used to create regulations implementing the relevant EU Directives.

Since the Single European Act came into force in July 1987, a significant number of Article 118A directives have been introduced, most of which have been implemented as regulations in terms of Section 15 of the 1974 Act. It is now the case that most workplaces and hazards have some form of regulation based on an Article 118A directive which makes it very difficult for the UK Government to exert any real influence on the direction of domestic health and safety regulation. When an Article 118A directive has been adopted, the member states have no choice but to implement them within their own legal framework. This makes it impossible for member states to unilaterally repeal legislation based on such directives.

There has been some criticism in the UK of directives being ‘gold-plated’, the implication being that the Government adds significantly to the requirements contained in the original directives when implementing them, including those dealing with workplace safety. Although this accusation is frequently levelled at government departments, the evidence would seem to suggest that ‘gold-plating’ is not a common occurrence when implementing directives. The enforcement of the directives and penalties for non-compliance rests with the

member state which obviously raises questions about the consistency of implementation and enforcement across the European Union.\textsuperscript{362} In the event of any conflict between EU and UK law, EU law has primacy which means that where EU law contradicts or is in conflict with UK domestic laws, it will supersede them.\textsuperscript{363} The European Court of Justice is the judicial arm of the European Union and its judgements “...overrule those of national courts”.\textsuperscript{364}

The influence of the European Union in the field of workplace health and safety cannot be overstated. As with many other social, environmental and financial issues, responsibility for developing strategy and policy with regards to workplace safety has been removed from the Government other than the influence that can be exerted as a member of the European Union. The UK Government has little choice but to implement directives and determine enforcement strategy within the constraints imposed by the European Union. One of the recommendations of the Löfstedt report was for the Government to work more closely with the European Union to encourage a risk-based approach rather than the hazard-based approach that was considered by the author to impose unnecessary burdens on employers. There was a recognition that an attempt to influence policy was all the Government can do in reducing the volume and nature of health and safety regulation emanating from Europe.\textsuperscript{365}

3.9 Deregulation

Although it is based on the concept of self-regulation, the 1974 Act has been the subject of deregulation proposals a number of times since its introduction, most notably by the Thatcher government in the nineteen-eighties although Baggott suggested that self-regulation and deregulation are not “...necessarily incompatible...”.\textsuperscript{366} This may be the case but only where organisations can be

\textsuperscript{362} Baldwin and Cave, \textit{Understanding Regulation. Theory, Strategy and Practice} op. cit. n.359, p.158 et seq.
\textsuperscript{363} Gary Slapper and David Kelly, \textit{The English Legal System} (5th edn, Cavendish Publishing 2001) 567
\textsuperscript{364} Ibid
\textsuperscript{365} Löfstedt, \textit{Reclaiming health and safety for all: An independent review of health and safety legislation. Cm 8129} op. cit. n.300, p.65
\textsuperscript{366} Baggott, ‘Regulatory Reform in Britain: The Changing Face of Self-Regulation’ op. cit. n.240, p.450
trusted to self-regulate in the interests of society in general and not just for their own shareholders or clients (or itself). Deregulation is defined in the context of corporate crime by Slapper and Tombs as “…a removal of laws designed to regulate the corporation, or perhaps the explicit withdrawal from the enforcement of existing laws”. The origins of deregulation can be traced to the USA and the Carter administration in the late nineteen-seventies but it was accelerated by the Reagan administration in the early nineteen-eighties, which included the Occupational Safety and Health Act of 1970, a piece of legislation Calavita describes as largely symbolic, at least initially. The deregulation of workplace health and safety in the USA as a result of the Reagan administration’s actions led to a dramatic reduction in almost every aspect of the Occupational Safety and Health Administration’s activities. Calavita is careful to point out that deregulation is not necessarily an outcome of any particular political party, the OSH Act was introduced by the Nixon administration, a pro-business Republican government and deregulation was introduced by the Carter administration, which was Democrat, although it must be recognised that the process was greatly accelerated by the Reagan administration. If the introduction of deregulation was not a party political issue, it could only have been driven by ideology and that ideology was embraced by the Thatcher government elected in 1979.

The Thatcher government is generally associated with the acceleration of a free market approach to industry and commerce along with a reduction in state regulation of a range of activities from bus services to the financial markets. Its intent is best demonstrated by the publication ‘Lifting the Burden’ which stated the desire to reduce “…burdens imposed on business by administrative and legislative regulation” including health and safety regulation. In many respects the recommendations included in ‘Lifting the Burden’ relating to health and safety in the workplace, focussed on enforcement and the relationship between the regulators and businesses, rather than reducing the number of regulations. ‘Lifting the Burden’ was followed up in 1986 by ‘Building Business,
Not Barriers’ which reported on the progress made in following the publication of the former.\footnote{Department of Trade and Industry, \textit{Building Business, Not Barriers} (Cmd 9794, HMSO, 1986)} It was clear from both publications that health and safety regulation was perceived by the Government as a burden on business but it, and the 1974 Act, emerged generally unscathed from the deregulation fervour exhibited by the Government of the time.\footnote{Dawson and others, \textit{Safety at work: the limits of self-regulation} op. cit. n.254, p.256} As James and Walters observed, “...the successive post-1979 Conservative governments did not prompt any fundamental changes to the regulatory system for health and safety established under the HSW Act” although it could be argued the level of enforcement activity by the Health and Safety Executive and local authorities was inevitably affected.\footnote{James and Walters, \textit{Regulating Health and Safety at Work: An Agenda for Change?} op. cit. n.334, p.9} With the election of a Labour government in 1997, the Deregulation Unit set up by the previous Conservative government was renamed the Better Regulation Unit and a Better Regulation Task Force was established.\footnote{Steve Tombs and David Whyte, ‘A Deadly Consensus: Worker Safety and Regulatory Degradation under New Labour’ (2010) 50 British Journal of Criminology 46 5} The Better Regulation Task Force was subsequently replaced by the Better Regulation Commission which was eventually disbanded in 2008. The proposition that health and safety is a burden to businesses has been most recently revived with the appointment of Professor Ragnar E. Löfstedt to “…look into the scope for reducing the burden of health and safety regulation on business, whilst maintaining the progress that has been made in health and safety outcomes” which resulted in “Reclaiming health and safety for all: An independent review of health and safety legislation”.\footnote{Löfstedt, \textit{Reclaiming health and safety for all: An independent review of health and safety legislation}. Cm 8129 op. cit. n.300, Forward} For the reasons discussed previously in this Chapter, there is no reason to suspect that Löfstedt will be any more successful in reducing health and safety regulation than his predecessors.

\section*{3.10 Conclusion}

As this Chapter has illustrated, the 1974 Act embodied a radical approach to the regulation of workplace health and safety but from the very start it was not without its critics. The fact that it is still in force after so many years could be
considered confirmation, to at least some extent, that its risk-based approach and administrative measures for contraventions has worked to a greater or lesser extent. The risk-based approach has been adopted in many other countries and although it did not have its origins in the 1974 Act, it was certainly given a degree of credibility that it might not otherwise have achieved. The development of administrative enforcement mechanisms in the form of improvement and prohibition notices was also a significant change in approach to health and safety offences, although once again, not entirely original. The concept of “so far as is reasonably practicable” as a qualification for duty holders has been subject to a great deal of discussion and debate since its adoption for the 1974 Act and it is inevitable it will continue to be so in the future.

The 1974 Act and the relevant statutory instruments have withstood attack by various governments, at least in part due to the requirements of the European Union. With all its faults, the Health and Safety at Work etc. Act 1974 continued relatively unchanged in its basic approach to workplace health and safety until the introduction of the Health and Safety (Offences) Act 2008. The original emphasis on outcome, that is, the protection of workers and others affected by work activities, rather than input which could include processes, systems, guidance, and so on, has resulted in a piece of legislation able to accommodate some significant changes in society and industry since its introduction. The duties imposed upon employers and others by the Act have provided an approach to worker safety capable of meeting the demands of the twenty-first century. There have been no serious proposals to repeal and replace the 1974 Act which demonstrates that although it does have faults, it also has many strengths that maintain its relevance more than forty years after its introduction. The 2008 Act has addressed some of the earlier criticisms of the 1974 Act by creating a range of penalties that should start to see health and safety breaches as truly criminal, rather than regulatory and this in itself will see employers and others responsible for health and safety taking it more seriously since imprisonment is now a realistic outcome in the event of breaches of the legislation.

There was one significant perceived area of weakness in the 1974 Act and its relevant statutory provisions, and that was its inability to deal effectively with
fatalities arising from work activities. As discussed in this Chapter, the 1974 Act deals with contraventions of the relevant statutory provisions, not their consequences. There is no offence in the Act or any of the relevant statutory provisions of causing death as a consequence of work activities and whilst fatalities may influence the penalties imposed by the courts, they form no part of the offence. Following the introduction of the 1974 Act, a number of accidents with a significant loss of life led to an outcry against what was generally considered to be inadequate punishment for those held to be responsible, both individuals and organisations. The larger the organisation, the less likely it was to be held to be properly accountable for its failings, or at least that was the perception amongst a large section of the community. This apparent failing of the 1974 Act to properly account for workplace deaths will now considered in the following chapters.
4.0 Corporate Killing

*Corporate crime remains an obscure and seriously misunderstood phenomenon.*\(^{376}\)

4.1 Introduction

While the Health and Safety at Work etc. Act 1974 was a radical approach to workplace safety when it was introduced, it did have a number of shortcomings, perhaps the most significant being its failure to specifically address deaths arising from work activities. With an emphasis on prevention rather than punishment, it addressed the causes rather than the effects of the breaches and as a consequence tended to neglect fault, the impact on victims and their families, the social need for punishment and so on. This attitude towards fault, impact and the need for punishment can be at least partly attributed to when the Robens Report was published but also reflects the character of the chairman. It would be the nineteen-eighties before the behaviour of companies, corporations and other organisations would be called into question as a result of deaths arising from work activities, and in particular serious accidents with multiple fatalities.

Breaches of the 1974 Act were based on failure to comply rather than any effects of that failure, although these would be taken into account in sentencing. This apparently unsatisfactory state of affairs was highlighted following a series of major accidents in the United Kingdom each resulting in a large number of fatalities. The perception that large organisations responsible for causing these deaths were not being properly punished led to a growing demand for a more effective response to such events. This clamour for ‘something to be done’ eventually led to the Corporate Manslaughter and Corporate Homicide Act 2007 but before that Act is discussed in detail, it is necessary to examine the nature of corporations and consider why Robens’ statement that “...there is a greater natural identity of interest between ‘the

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two sides’ in relation to safety and health problems than in most other issues.”

would appear to be misguided at best and, more likely, completely wrong. The question of whether or not corporations and other large organisations can realistically be expected to protect the safety and health of workers and others affected by their activities, perhaps at the expense of profit, must be addressed. Without the threat of prosecution and subsequent punishment commensurate with the severity of the offence, will organisations spend the time, trouble and effort necessary to prevent fatal accidents arising from their activities? The catalogue of workplace disasters in the late twentieth and early twenty-first centuries would suggest not.

Whether or not the failure to effectively punish corporations for deaths arising from their activities can be blamed on the Health and Safety at Work etc. Act 1974 is questionable. It was never Robens’ intention to tackle this issue; the emphasis of his Report and the 1974 Act was on making the law dealing with workplace safety more effective in protecting workers. That being the case, any criticisms of the 1974 Act in respect of its inability to deal with workplace deaths is misplaced. If the 1974 Act was neither intended nor able to deal with workplace deaths, there were few choices available to respond to such events in a manner acceptable to the population at large and this became increasingly apparent towards the end of the twentieth century.

Many of the problems encountered in taking appropriate action following workplace deaths can be attributed to the nature and structure of organisations, particularly the larger ones with complex and extensive management structures. It is fair to say that in the United Kingdom there was no effective mechanism until the twenty-first century to punish large corporations specifically for work-related accidents that resulted in the deaths of employees or members of the public. This Chapter will examine the nature of corporations and why their priorities may not be the protection of the health and safety of workers and others who may be affected by their activities. The concept of corporate crime will also be examined, including its perception by the legal profession and how it is addressed by the law.

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377 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.21
4.2 Corporations

Before corporate crime can be discussed, it is necessary to consider the nature of corporations and in particular, why that nature can result in behaviour that would be unlawful were it to be conducted by an individual. Whilst it should be noted that not all the organisations discussed in this thesis were established as corporations, they share at least some of the characteristics and in any case, 2007 Act extends beyond the normal definition of corporation. In order to understand why the Corporate Manslaughter and Corporate Homicide Act 2007 was considered necessary, the concept of corporations must be examined including why some commentators argue that they cannot be expected to act in what could be considered a responsible manner.\(^{378}\) This apparent failure to behave responsibly is considered by some commentators to be at least partly as a consequence of their nature, and to understand something of that nature, it is necessary to examine the origins of corporations. According to Micklethwait and Wooldridge, the Romans first established what could be considered corporate laws although it would not be until the 12\(^{th}\) and 13\(^{th}\) centuries that corporations started to emerge in anything like a form that could be recognised today with the Aberdeen Harbour Board, established in 1136, probably being the first recorded corporation, and one of the world’s best known corporations, the City of London was established during the same period.\(^{379}\) It is worth noting that the very earliest incorporations were public, rather than private, and that continued to be the case for many corporations through to the nineteenth century.

From the development of corporation law in England as a coherent framework in the fifteenth and sixteenth centuries and until the late eighteenth/early nineteenth centuries, incorporation was a mechanism mainly used for local government administration, companies of merchants and guilds and universities.\(^{380}\) Although it may seem that these institutions had little in

\(^{380}\) Joan C. Williams, 'The Invention of the Municipal Corporation: A Case Study in Legal Change' (1985) 34 Am U L Rev 369 373
common with each other, each had charters which excluded them from feudal obligations. According to Williams, the process by which these chartered institutions became corporations is obscure but in England it was viewed that charter grants were grants of corporate status. The concept of public and private powers did not exist at that time with corporate boroughs undertaking activities that could fall under either category. The distinction between public and private corporations would not properly appear until the mid-nineteenth century.\footnote{381}

In his 1793 Treatise on the Law of Corporations, Kyd defined a corporation as “...a collection of many individuals, united into one body, under a \textit{special denomination} (Kyd’s emphasis), having perpetual succession under an \textit{artificial form}, and vested, by the policy of the law, with the capacity of acting, in several respects, as an \textit{individual}, particularly of taking and granting property, of contracting obligations, and of suing and being sued, of enjoying privileges and immunities in \textit{common}, and of exercising a variety of political rights, more or less extensive, according to the design of its institution, or the powers conferred upon it, either at the time of its creation, or at any subsequent period of its existence.”\footnote{382} Kyd’s definition extended Coke’s (as cited in Laski) who, in 1612, stated that “A corporation aggregation of many is invisible, immortal, and rests only in intendment and consideration of the law.”\footnote{383}

The nature of corporations has not changed significantly since Kyd’s Treatise with many of the characteristics he identified still forming the basis of corporations today. Kyd was absolutely clear that a corporation could only act in the capacity for which it was established and could not “…be considered as a moral agent subject to moral obligation…” having neither “…soul nor body”. The latter concept developed into an important part of the subsequent understanding of corporations and, in particular, the view that a corporation can have no moral fault or \textit{mens rea}. The idea that corporations have neither soul nor body was not new when Kyd was writing and is often attributed to Edward, First Baron of Thurlow (1731 -1806) who inquired “Did you ever expect a

\footnotesize{381} Ibid
\footnotesize{382} Stewart Kyd, \textit{A Treatise on the Law of Corporations}, vol Vol. 1 (J.Butterworth 1793) 13
corporation to have a conscience, when it has no soul to be damned, and no body to be kicked?”. The idea that corporations are not subject to any moral obligation (unless explicitly included in the terms of their incorporation) has frequently been used to explain their behaviour with regards to health, safety and the environment and is a recurrent theme in much of the research into corporate crime.

At the beginning of the nineteenth century, incorporation in the United Kingdom required an Act of Parliament which was both time consuming and costly, and carried the potentially high risk of failure. Between 1834 and 1885 various Acts of Parliament were introduced giving companies a range of rights, including limited liability (subject to registering under the Companies Act), although that particular right was one of the last to be afforded to all registered companies. The nature of corporations changed during that time with Morawetz suggesting that “The ultimate object of every ordinary trading corporation is evidently the pecuniary gain of its shareholders” before going on to say that “…for this purpose and no other have the shareholders advanced their shares of the capital”. Whilst legislation dealing with companies and incorporation has continued to evolve over the succeeding century and a half, the process for the creation of corporations with limited liability and their nature and character was, to all intents and purposes, established in the UK by the end of the nineteenth century. Although the evolution of corporation law has been different in the United Kingdom and the United States, the nature of corporations in both countries is similar in many respects resulting in “…corporate law as evolving more less steadily towards its modern form as a result of the pressures exerted by self-interested businesses”.

Before moving on, it is worth considering one particular US case which has been cited on both sides of the Atlantic, The Trustees of Dartmouth College v.

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385 Geoffrey Todd, ‘Some Aspects of Joint Stock Companies, 1844-1900’ (1932) 4 The Economic History Review 46 47
Woodward, where Marshall, C.J. described a corporation as “...an artificial being, invisible, intangible... it possesses only those properties which the charter of its creation confers upon it either expressly or as incidental to its very existence”. In spite of being US Case Law, Dartmouth College v. Woodward has had an important influence in understanding what a corporation is, both there and in the United Kingdom. Involving the attempt by New Hampshire to change the charter of incorporation of Dartmouth College, the judgement by Woodward (in favour of the College) discussed at some length the nature of corporations. In addition to describing what a corporation was, he went on to propose that corporations were invented “...chiefly for the purpose of clothing bodies of men”. He went to state that corporations were “...deemed beneficial to the country...” and accordingly that benefit was to be considered an “ample compensation” for the faculty it afforded them. This would imply that, at the time of the judgement, corporations were perceived to be created for the public good, rather than shareholders or members although making a profit was not considered incompatible with that aim. The idea that incorporation was “...beneficial to the country...” would seem to have faded by the middle of the nineteenth century although the ‘public corporation’ created (normally by government) for the benefit of society at large, rather than shareholders and employees, continued but without the same degree of scrutiny as ‘private corporations’.

It should be noted that in the United States at that time (and still to this day), incorporation was a state function with each state taking a different approach to the granting of limited liability to corporations. There can be significant tax, regulatory and administrative advantages for US and other international companies to incorporate in Delaware, best demonstrated by the statistic that in 2012 almost half of all United States public corporations were incorporated there. One area where the approach in the United States differs from other

388 Trustees of Dartmouth College v. Woodward (1819) 17 US 518 636
389 Ibid
391 Micklethwait and Wooldridge, The Company: A Short History of a Revolutionary Idea op. cit. n.379, p.47
countries, including the United Kingdom, is that a public corporation in the US may refer to one whose shares are publicly traded whereas in the UK and other countries, it refers to an entity established by central or local government, or some other public entity.  

Corporations and corporate law evolved over the late nineteenth, twentieth and early twenty-first centuries, and “...continued growing and continued inventing and perfecting new methods for creating wealth.” The legal characteristics of corporations are variously described by commentators, for example, Calder identified four significant characteristics, it is a legal entity, has transferable shares, independence from shareholders and has limited liability. Kraakman et al identified five “core” characteristics of any corporation, legal personality, limited liability, transferable shares, centralised management and shared ownership. Although a slightly different approach has been taken in each, they are sufficiently similar to establish a common set of characteristics for any modern corporation which would include a separate legal entity or personality, limited liability, shareholders and an independent management. In the UK, the establishment, management and operation of corporations and other organisations must conform to the requirements of the Companies Act 2006 which comprises forty-six parts in over seven hundred pages and deals with most aspects of corporations including their characteristics discussed above and below. To enjoy the benefits that incorporation can bring, a company must comply with the requirements of the Companies Act 2006 including registration. Upon registration, a certificate of incorporation is issued by the registrar. It should be noted that certain requirements of the Companies Act will apply to companies that are not incorporated

The concept of a separate legal entity and limited liability have been discussed previously in this section but the role of shareholders in corporations requires further explanation. Corporations are effectively owned by their investors, the shareholders, who are entitled to both participate in their control and receive a

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393 HM Treasury, Public Expenditure Statistical Analyses (PESA) 2011 Cm8104 (TSO, 2011) 99
394 Alan Calder, Corporate Governance: a practical guide to the legal frameworks and international codes of practice (Kogan Page 2008) 8
395 Ibid
397 Companies Act 2006
share of profits in proportion to their investment.\textsuperscript{398} It is clearly in the shareholders’ interests to appoint directors and other senior managers who will focus on maximising their benefits, normally through focussing on profit, perhaps at the expense of other considerations. Cahill and Cahill suggested that modern companies are “...constantly under pressure from shareholders and competitors to maximize output at minimum cost which means that what is best for the corporation and what is best for society are rarely the same thing.”\textsuperscript{399}

The next section will examine what it is about the nature of corporations that can lead them to conduct their activities in a criminal manner.

4.3 Criminal Corporations

Corporations are not the only form organisations can take; they also exist as sole proprietors and partnerships, amongst others, but there are particular characteristics of a corporation that makes it perhaps more attractive than the alternative forms. Monks and Minow described corporations as “...a mechanism established to allow different parties to contribute capital, expertise, and labor, for the maximum benefit of all of them”.\textsuperscript{400} While this might express the purpose of a corporation, it does not explain what makes an organisation a corporation and while the process of incorporation in law has already been described, there are other very important characteristics of incorporation that may facilitate criminal behaviour. These characteristics have been discussed in the previous section and include limited liability, independent entity with the sole aim of complying with the terms of its charter which would normally be to maximise the shareholders’ benefit.

There are many other characteristics unique to corporations but for the purposes of corporate crime, those mentioned in the previous paragraph could be considered the most relevant and have been used to explain why corporations exhibit a particular type of behaviour. Litowitz identified two main attitudes to

\textsuperscript{398} Kraakman and others, The Anatomy of Corporate Law. A Comparative and Functional Approach op. cit. n.396, p.13
\textsuperscript{399} Cahill and Cahill, ‘Scarlet Letters: Punishing the Corporate Citizen’ op. cit. n.16, p.153
\textsuperscript{400} Robert A. G. Monks and Nell Minow, Corporate governance (Blackwell Publishing 2003) 9
corporate criminality; either a “...destructive behemoth that needs to be radically changed” or corporations as sources of “...tremendous productivity, innovation and liberty” with any wrongdoing attributable to a few individuals employed by them and driven by personal greed.401 He suggested that it is not corporations in themselves that are “evil”, but any large, impersonal institution in which individual workers are reduced to “...an agentic state of submission...” where they allow others to direct their actions whilst at the same time being distanced from their consequences, since the responsibility is transferred to those giving the directions.402 He concluded that the most significant cause of corporate wrongdoing is an economy built on a workforce that lacks the ability to refuse orders in the workplace and that it is the “...economic and cultural system...” that causes individuals to act in a deviant manner when they work for the largest institutions. While Litowitz may have been correct in suggesting that, ultimately, individuals are responsible for the actions of any large organisation, whether it is a corporation or not, and that size as well as the nature of the organisation will have an influence on its behaviour, there is a still an argument to be made that the specific nature of corporations can encourage them to behave in a manner that would be considered criminal under any other circumstances.

Although corporations are “entities”, they may not be subject to criminal law in the same way that an individual could be under the same circumstances. As Orland pointed out, a corporation cannot be imprisoned (although it can be ‘executed’, in so far as it can be wound up) but neither does it engage in some forms of criminal activity, such as murder and sex.403 He went on, however, to suggest that there have been exceptions to this rule, citing the manslaughter indictment brought against the Ford Motor Company in respect of manufacturing and design defects associated with its Pinto model and although it should be noted that the offences of murder and manslaughter are quite different, as will be discussed in the next Chapter, and while it was perhaps not the best example

402 Ibid
403 Orland, ‘Reflections on Corporate Crime: Law in Search Theory and Scholarship’ op. cit. n.376, p.502
to give, it did demonstrate the potential for corporate criminality.\textsuperscript{404} Given the number of deaths associated with corporate misbehaviour, it could be argued that cases like this are not necessarily the exception and there are many other equally persuasive examples demonstrating that corporations are more than capable of engaging in activities that could be described by some commentators as ‘murder’ if carried out by an individual.

Kagan and Scholz proposed three theories of noncompliance to explain deviant behaviour by corporations; the corporation as an “amoral calculator”, the corporation as a “political citizen” and the corporation as “organizationally inept”, suggesting a different regulatory approach for each.\textsuperscript{405} The corporation as an amoral calculator describes behaviour resulting in deliberate unlawful actions taken in the single-minded pursuit of profit where potential gain will be assessed against any potential legal action arising as a consequence of law-breaking. The decision to act unlawfully will be based on a cost-benefit analysis, that is, the potential profit of the unlawful acts measured against any financial or other penalty should enforcement action be taken in respect of these acts. The likelihood of any such enforcement action will also influence the calculation made by the corporation; if there is a small, or non-existent, chance of being caught, there is even less reason for the corporation to behave in a lawful way.

The Ford Motor Company’s response to the deaths caused by fire engulfing its Pinto model in the nineteen-seventies referred to previously in this Chapter, is frequently used as an example of the corporation as an amoral calculator and a solid illustration why corporations can only be expected to act in their own interests. The Ford Pinto has become something of a \textit{cause célèbre} in the field of corporate killing and has been subject to much analysis, discussion and debate. The Pinto was designed by Ford in the late nineteen-sixties to compete with a flood of imports of small cars from both Europe and Japan.\textsuperscript{406} As a consequence of competition from other manufacturers, and perhaps more

\textsuperscript{404} Ibid
\textsuperscript{406} Mark Dowie, ‘Pinto Madness’ in Stuart L. Hills (ed), \textit{Corporate Violence Injury and Death for Profit} (Corporate Violence Injury and Death for Profit, Rowman & Littlefield 1987) 16
importantly, an opportunity to take advantage of a relatively new market for Ford, the development of the Pinto was scheduled to be completed in twenty-five months, rather than the more typical forty-three. The critics of the Pinto suggested that safety suffered as a consequence of this compressed development stage resulting in a car that had fundamental safety flaws, not least of which was the location of the fuel tank between the rear bumper and rear axle, rather than saddling the rear axle which was a relatively common arrangement and much safer. The Ford Pinto was very much designed to a price and even relatively low cost design modifications were omitted to keep the cost as low as possible.

At least partly as a consequence of its design and decisions made to keep costs as low as possible, the Pinto was prone to leak fuel following rear-end collisions, even at relatively low speed, and should the leaked fuel ignite deaths or injuries could result to drivers and passengers, which proved to be the case. The actual number of deaths from burning or smoke inhalation is unclear, with Dowie suggesting that by “...conservative estimates Pinto crashes have caused 500 burn deaths...”, whereas Wells, citing Cullen et al put the estimated number of burn deaths caused by the design features of the Pinto at 26. Although the discrepancy in the number of burn deaths in Pintos is not particularly relevant here, it is worth commenting upon because these figures will almost certainly have informed public opinion and influenced how Ford was perceived at the time. Dowie provided no evidence for his figures but the figure of 26 cited by Wells is close to the estimated 27 burn deaths from Pinto accidents published by the NHTSA. Some of these deaths and injuries resulted in various actions against the Ford Motor Company, perhaps one of the more interesting being its indictment in Indiana for reckless homicide following the deaths of three teenagers when their Pinto was driven into from the rear resulting in a fuel explosion. Although the prosecution was ultimately unsuccessful, a great deal of

\[^{407}\text{Ibid; C. Wells, } \text{The decline and rise of English murder: corporate crime and individual responsibility} \text{ (1988) Criminal Law Review 788 794 citing F. Cullen et al , } \text{“The Ford Pinto Case and Beyond: Corporate Crime, Moral Boundaries and the Criminal Sanction,” in E. Hochstedler (ed.) Corporations as Criminals (Sage, 1984), 107. 124.}

\[^{408}\text{Gary T. Schwartz, } \text{‘ The Myth of the Ford Pinto Case ‘ } \text{(1991) 1013 (1990-1991) 43 Rutgers L Rev 1013 1030}
publicity was generated by this case, including the revelation of what subsequently became known as the Grush-Saunby Report.

The existence of the Grush-Saunby Report has been used by a number of commentators to paint the Ford Corporation as an amoral calculator in respect of the safety of its motor vehicles generally, and in particular the well-established vulnerability of the Pinto to fuel leakage following a rear-end collision. The Grush-Saunby Report was produced by two Ford engineers in response to proposals by the US Government to regulate certain aspects of motor vehicle design in order to improve survivability in various types of accidents, including those resulting in fire and explosion. The report focussed specifically on fuel leakage following rollover-type accidents, so it was not immediately relevant to the types of accident discussed above where the fuel leakage arose from rear-end collision, but very importantly and somewhat dammingly, the Report included a cost-benefit analysis which provided the evidence that Ford had put a value on human life when considering the costs of improving safety. The cost-benefit analysis was based on the cost of reducing the likelihood of fuel leakage following a rollover accident for all vehicles (not just the Pinto) and comparing that cost against the cost to the Corporation of paying compensation for those killed or injured as a consequence. Based on 180 burn deaths per annum at a cost of $200,000 each (slightly lower than the cost of a life calculated by the National Highway Traffic Safety Administration (NHTSA) of $200,725 (although the NHTSA made it clear that was the minimum value when considering highway safety improvements)), 180 serious burn injuries at a cost of $67,000 each and 2100 vehicles damaged by fire at $700 each, the benefits in making the improvement would be around $49.5 million. The cost to the motor industry was based on reducing the likelihood of fuel leakage ($11 per vehicle) for 11 million cars and 1.5 million light trucks (these

410 E.S. Grush and C.S. Saunby, Fatalities Associated with Crash Induced Fuel Leakage and Fires (Ford Motor Company, 1973)
411 Dowie, ‘Pinto Madness’ op. cit. n.405, p.20
figures related to the total motor vehicle production in the US, not just those produced by Ford), amounting to a total of $137 million, resulting in a cost almost three times the benefit, when measured monetarily.

The Grush-Saunby report has been referred to as the “smoking-gun”, and incontrovertible proof that Ford cared little about the safety of its customers but that is reading far too much into what could be considered a fairly sensible, if somewhat misguided, approach to vehicle safety. There can be no doubt that every motor vehicle manufacturer will carry out a similar calculation when developing and marketing their products. From seatbelts to airbags, motor vehicle manufacturers have always put a price on safety, knowing that the inclusion of various design features will save lives and Ford is not the only manufacturer to allow their vehicles to continue on the road knowing that they could result in death or injury. In an article criticising the decision to take criminal action against Ford following the accident and subsequent deaths in Indiana, Epstein pointed out that in carrying out a cost-benefit analysis of the type described above, “… Ford did so in compliance with court decisions announcing that such computations will avoid civil liability…”. Ford may have got it sums wrong in this case but that does not necessarily make the basic approach wrong. The nature of the deaths associated with the Pinto and the rather compassionless language used by Grush and Saunby in their report certainly made Ford appear as an amoral calculator and its response to the Grush-Saunby report would seem to demonstrate there was no place for compassion in the corporate structure prior to any accidents. The Ford Pinto was by no means the worst performing small motor vehicle in respect of burn deaths on sale in the US at that time but as a consequence of circumstance, it and the company responsible for its manufacture became notorious in what has been described by the Association of Trial Lawyers of America as one of the top 10 civil cases of the millennium. At least partly on the basis of the Ford Pinto and the Chevrolet Corvair manufactured by General Motors in the 1960’s,

414 The Chevrolet Corvair was introduced by General Motors in 1959 and the first generation gained notoriety as a consequence of the design of its rear suspension resulting in poor and unpredictable handling. In Ralph Nader’s Unsafe at Any Speed, The Designed-In Dangers of The American Automobile (1965) Grossman Publishers, New York, in much the same way as Ford but
Pearce drew the conclusion that some corporations will, from time to time, act as “...ruthless and knowing ‘amoral calculators’”.  

The Ford Motor Corporation (and General Motors) may have satisfied many of the characteristics associated with the theory of amoral calculator in respect of the Pinto and Corvair and most observers would certainly describe their behaviour as such, at least in Kagan and Sholz’ terms there is one very important area where they did not, namely their activities were not illegal, no laws in force at that time were contravened. Ford was found not guilty of the culpable homicide charge brought against it in Indiana although it was found guilty of negligence and strict liability in a civil action where it was require to pay $2.5 million in compensatory damages and $125 million (subsequently reduced to $3.5 million) in punitive damages to the victim of the crash, who survived but suffered serious and life changing burns to his face and body, and $560,000 to the family of the driver of the car who subsequently died.

If the absence of unlawful activity meant that Ford did not satisfy all the criteria for amoral calculator in respect of its attitude in the Pinto case, and it could be argued that the absence of unlawful activity should not be taken into account, using the theories of Kagan and Sholz, its actions might better fit the theory of the corporation as political citizen, which is predicated on corporations being “…generally disposed to obey the law…” but adopting a policy of non-compliance when faced with what they consider to be unreasonable or arbitrary regulatory burdens. In effect, corporations will tend towards social responsibility unless faced with what they consider to be unreasonable demands imposed by the state, categorised by Pearce as unreasonable laws, excessive damages, unworkable regulations and refusal of product certification. Pearce suggested that although corporations may wish to see themselves as socially responsible, claiming to be political citizens as defined by Kagan and Sholz, he considered

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for different reasons, General Motors was criticised for putting profit above safety by selling a product which Nader alleged had known safety defects.

415 Frank Pearce, ‘Responsible Corporations’ and Regulatory Agencies’ (1990) 61 The Political Quarterly 415 420


417 Pearce, ‘Responsible Corporations’ and Regulatory Agencies’ op. cit. n.415, p.416
such a claim to be untenable, concluding that “...many corporations act, on occasion, as amoral calculators...”.

The final theory put forward by Kagan and Sholz to explain deviant behaviour by corporations is that of incompetence, where disorganisation or corporate mismanagement is at the root of much of their unlawful acts and activities. They went on to discuss the identification of “…corporate ignorance, incompetence, inattention and internal conflict to regulatory violations...” by regulators and executives as a common cause of deviance by corporations. As Kagan and Sholz pointed out and has been discussed elsewhere in this thesis, Robens in his report on occupational health and safety legislation argued that most contraventions arose through “carelessness, oversight, lack of knowledge or means, inadequate supervision or sheer inefficiency”. Pearce suggested that “…safe firms are efficient firms and vice versa” implying that disorganised, mismanaged, incompetent firms are unsafe. The theory of incompetence might explain the immediate causes of deviation, particularly in the area of workplace health and safety but it does not explain the root causes which may still be attributed to the corporation as amoral calculator in so far as the disorganisation or mismanagement has been allowed to develop within it.

The view of corporations as amoral calculators is one of the most commonly subscribed to by those commentators who view corporations as ‘evil’ or ‘psychotic’, an attitude perhaps best expounded by Bakan who stated that there were “No internal limits, whether moral, ethical, or legal...what or whom corporations can exploit to create wealth for themselves and their owners”. In a similar vein, Mintz accused corporations of acting “…without compassion and no matter what damage they cause, without remorse”. Kagan and Sholz acknowledged that the perception of corporations as amoral calculators will “…dominate the ‘criminology of the corporation’ in modern Western society.

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418 Ibid
419 Kagan and Scholz, ‘The “Criminology of the Corporation” and Regulatory Enforcement Strategies’ op. cit. n.405, p.365
420 Robens, Safety and Health at Work. Report of the Committee 1970-72 op. cit. n.20, p.82
421 Pearce, ‘Responsible Corporations’ and Regulatory Agencies’ op. cit. n.415, p.422
422 Bakan, The Corporation. The Pathological Pursuit of Profit and Power op. cit. n.378, p.111
Pearce drew attention to the distinction made by Kagan and Sholz between the vast majority of large corporations claiming to be socially responsible and the minority of small, marginal corporations behaving as amoral calculators suggesting that there is little evidence to support such a distinction with large corporations having at least as many, if not more, offences recorded against them.424 Orland found that in his examination of 1978 Security and Exchange Commission (SEC) filings “...14 out of 100 of the largest industrial corporations disclosed criminal convictions...” indicating a significant proportion of corporations participate in criminal behaviour and since these are only the recorded convictions, it must be assumed that the actual level of crime is higher.425 Indeed, he suggests that “…the gap between recorded and actual corporate crime may be even greater than for other forms of crime”.426 In his survey of Factories Acts’ offences by 200 firms between 1961 and 1966, Carson found that each had been guilty of at least 2 violations, with one firm being responsible for 94 violations.427 This would tend to support the view that corporations and other organisations will routinely commit violations, whether as amoral calculators, political citizens or organisationally incompetent.

Other theories have been developed to explain the behaviour of corporations, for example, Yeager identified the ‘moral’ corporation which complies with legislation, the amoral corporation which takes a “...rational/calculating...” approach to compliance, but he also introduced a further category, that of the immoral corporation. He described the immoral corporation as having “…an aggressively antiregulation culture...” that demonstrates an abhorrence of regulation or other interference with its activities.428 It must be assumed that immoral corporations are on the margins of society, an extremely small minority and, by their very nature, operating outside the legal framework, unlike the other forms of non-compliant behaviour where the corporation will almost

424 Kagan and Scholz, ‘The “Criminology of the Corporation” and Regulatory Enforcement Strategies’ op. cit. n.405, p.371; Pearce, ‘Responsible Corporations’ and Regulatory Agencies’ op. cit. n.415, p.419
425 Orland, ‘Reflections on Corporate Crime: Law in Search Theory and Scholarship’ op. cit. n.376, p.510
426 Ibid
428 Peter Cleary Yeager, ‘Management, Morality and Law: Organizational Forms and Ethical Deliberations’ in Frank Peace and Lareen Snider (eds), Corporate Crime Contemporary Debates (Corporate Crime Contemporary Debates, University of Toronto Press 1995) 147
certainly be law-abiding to a greater or lesser extent. Importantly, Yeager pointed out that within any large, complicated organisation, attitudes to morality will almost certainly vary.

Although taking a slightly different approach to Yeager and Kagan and Scholz, Punch also identified three categories based on the “...intentional element of management decision-making” which overlap with their approach. Whilst his first category is based around the deliberate decision by the organisation to participate in deviant behaviour, he did not believe that any legitimate corporation would take a decision or decisions that would knowingly lead to death or injury, instead suggesting that “...much of this is completed within “normal” and mostly legal business practice...”, making it much more akin to Kagan and Scholz’s ‘political citizen’ than ‘amoral calculator’. Punch’s next category of management decision making was ‘incompetence’, almost identical to Kagan and Scholz’s third theory, but his final category, based on work done by Vaughan and one that he described as “interesting”, is where an organisation considers it is acting within the formal procedures laid down whilst unaware or heedless of the unacceptable level of risk it is accepting. Vaughan, taking a sociological approach to organisational deviance, which she also described as ‘routine nonconformity’, suggested that they are “...the causal origins of unanticipated negative outcomes...” which would include the type of events discussed in this and subsequent chapters. Vaughan identified three forms of routine nonconformity; mistake, misconduct and disaster, describing them as “...systematic products of complex structures and processes...” allowing “...social context to decouple rational choice from outcomes...” thus resulting in decisions being taken that may lead to unwanted and unintended consequences. What Vaughan effectively suggested is that corporate deviant behaviour may occur unknowingly, at least for the organisation, there may be a perception within it of no wrongdoing and certainly none that could result in the devastating effects seen in some of the major accidents discussed in the next Chapter.

429 Punch, ‘Suite violence: Why managers murder and corporations kill’ op. cit. n.7, p.251
432 Ibid
Unlike Bakan, Minitz and others discussed previously in this Chapter, not all commentators hold the view that corporations are fundamentally amoral. Litowtiz discussed at length the conflicting perspectives of those commentators who hold the view that corporations by their very nature will undertake what he describes as immoral conduct to achieve their ends (most probably increased profits) and what he described as the apologist view, which holds that the immoral conduct arises from the actions of a few individuals, rather than corporations as entities.\(^\text{433}\) He went on to argue that it is not corporations, or other specific legal entities to blame for immoral conduct, but “...the real evil lies in institutions of a certain size...”, thus drawing a direct correlation between the size of an institution and its propensity to act in what would be considered an immoral or illegal way.\(^\text{434}\) Whilst there may be some merit in Litowitz’s argument, it is clear that small organisations are just as capable of acting in an immoral or illegal way but the senior management are more likely to be directly involved in those actions than the senior managers of large organisations.

Byrne pointed out that from their origins in medieval England, corporations had a dual function to provide both a return for their investors but also provide a public service such as infrastructure and facilitate commerce.\(^\text{435}\) He went on to suggest that the perception of the corporation as a tool only to generate profit for shareholders and with no social or public responsibility only started to hold sway from the late eighteenth century before becoming the dominant theory in the twentieth century. Byrne recommended that corporations must be made to consider their responsibility to the public and society at large as well as their shareholders and in many respects this change in attitude can be seen in the growing interest in good corporate governance and corporate social responsibility. In support of corporations, Micklethwait and Wooldridge made a strong defence for their role in shaping the western world over the past few centuries, excusing misbehaviour, irresponsibility and scandal in the context of what they considered to be the benefits associated with the corporate structure.\(^\text{436}\) They argued that it is in a corporation’s interests to actively

\(^{433}\) Litowitz, ‘Are Corporations Evil?’ op. cit. n.401, p.840
\(^{434}\) Ibid
\(^{436}\) Micklethwait and Wooldridge, The Company: A Short History of a Revolutionary Idea op. cit. n.379, p.181
engage with society at large and they illustrated that engagement with a number of positive examples ranging from education and health care to supporting disadvantaged and under-represented groups. In their view, this is not just to maximise profits, but to do good more generally. It should be noted, however, that although not alone in their support for corporations, the case made by Micklethwait and Wooldridge is very much in the minority amongst commentators on the behaviour of corporations.

Although mainly outside the scope of this thesis, the concept of corporate social responsibility is worth exploring in more detail since it has been mooted as an answer to some of the criticisms levelled against corporations in respect of some of their worst excesses discussed here and elsewhere in this thesis. The concept of corporate social responsibility has gained in popularity over the past 10 years or so, but Carroll traced its origins to the 1930’s and in the ‘modern era’, to Bowen in 1953 with the publication of Social Responsibilities of the Businessman. Carroll went on to define social responsibility as encompassing “the economic, legal, ethical, and discretionary expectations that society has of organizations at a given point in time.” Although one of the earliest definitions of corporate social responsibility, it is by no means the only one; Dahlsrud identified thirty-seven separate definitions by 2006, so it can reasonably be assumed that more will have been developed in the last ten years or so. His research suggested that most definitions of corporate social responsibility included five dimensions; stakeholder, social, economic, voluntariness, environmental. It is important to note that corporate social responsibility is a voluntary activity, there is no legal basis for it. Dahlsrud pointed out that none of the definitions “...actually defines the social responsibility of business ...but rather describe CSR as a phenomenon”, how organisations develop and implement a corporate social responsibility strategy within a particular context. As mentioned previously, the implementation of corporate social responsibility policies has become much more common over the

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438 Ibid
440 Ibid
past few years but there is absolutely no evidence that it will have any real consequences for corporate morality (or immorality) and it could be argued that it is a relatively low cost strategy for organisations to improve their public image without actually changing their business practices.

In theory, a commitment to corporate social responsibility should address most of the criticisms levelled against organisations discussed above but although many national and international organisations subscribe to its principles, it is not without controversy. Milton Friedman was one of the earliest critics of corporate social responsibility and citing his own book, argued that “...there is one and only one social responsibility of business - to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game...”\(^441\) In many respects this reflects the evolution of corporations discussed previously in this Chapter with the sole aim of a corporation being legally bound to the terms of its incorporation and in most cases that would be to maximise profit and shareholder return. Bakan, who could be expected to take a diametrically opposed view to Fieldman in most things, agreed in this respect and goes further to suggest that any corporation engaging in social responsibility activities would be acting illegally, unless it could be demonstrated that there is some kind of benefit to the organisation that would improve its competitiveness, profitability, etc.\(^442\) In effect, any activity, including social responsibility, must be in the interest of the corporation and/or its shareholders. In addition to being generally critical of the whole concept of corporate social responsibility, Glasbeek predicted its ultimate failure at least partly as a consequence of the various stakeholders (workers, consumers, environmentalists, and so on) having differing and in some cases conflicting interests whereas the corporate entities have only one main interest, that is, making a profit.\(^443\) He went on to suggest that while corporate image may improve “...for a while...” as a consequence of the development and implementation of a corporate social responsibility strategy, nothing will have really changed.

\(^{441}\) Milton Friedman, 'The Social Responsibility of Business is to Increase its Profits' *The New York Times Magazine* (New York September 13, 1970)

\(^{442}\) Bakan, *The Corporation. The Pathological Pursuit of Profit and Power* op. cit. n.378, p.37

\(^{443}\) H.J. Glasbeek, 'The Corporate Social Responsibility Movement - The Latest in Maginot Lines to Save Capitalism' (1987) 11 Dalhousie LJ 363 401
The potential for effective corporate social responsibility to reduce or prevent deaths arising from corporate activities is self-evident and, irrespective of whatever definition or dimensions are adopted, worker and public safety must be part of it. That being the case, it would be assumed that an organisation’s commitment to corporate social responsibility would be generally welcomed but that would appear not to be the case. Davis argued that voluntary initiatives such as corporate social responsibility have been shown to be ineffective in improving corporations’ health, safety or environmental performance.\footnote{Dr Courtney Davis, \textit{Making companies safe: What works?} (Centre for Corporate Accountability, 2004) 13} When arguing for corporate accountability through regulation, Christian Aid argued that voluntary approaches are totally inadequate in ensuring organisations live up to their corporate social responsibility commitments.\footnote{Christian Aid, \textit{Behind the Mask. The Real Face of Corporate Social Responsibility.} (2004) 53} Hart associated corporate social responsibility with self-regulation, at least so far as occupational health and safety is concerned, and concluded that the business case supporting it is weak, describing its use by government, regulatory agencies and corporations to support self-regulation as limited.\footnote{Susan Margaret Hart, ‘Self-regulation, Corporate Social Responsibility, and the Business Case: Do they Work in Achieving Workplace Equality and Safety?’ (2010) 92 J Bus Ethics 585 597} It is inevitable that the concept of corporate social responsibility will continue to be encouraged by government, corporations and regulators as an alternative to regulation with its voluntary approach being preferred by each, although perhaps for different reasons, but as with all self-regulation strategies, the cost-benefit analysis will always give preference to the main purpose of a corporation, that is, to maximise profit and shareholder return at the expense of worker and public safety.

The nature of corporations perhaps inevitably results in them committing immoral or deviant acts from time to time, which may or may not be illegal, but are certainly amoral. For most, their emphasis will be on maximising profit and shareholder return and it is all too common for that to be achieved at the expense of the safety of workers and other people, including customers. It is too easy to describe corporations that behave in what is subsequently considered immoral or deviant manner as amoral calculators, and whilst that will be appropriate in some cases, it does not properly describe all aspects of any
corporation and its behaviour. The evidence in this and other Chapters would indicate that most corporations will behave as amoral calculators at least some of the time but perhaps more commonly, incompetence is the root cause of the type of crime discussed in the following section. Incompetence is no more excusable as a cause of deaths and injury than acting amorally, indeed, it could be argued that it is less acceptable since it would imply an unacceptable level of thoughtlessness or carelessness exhibited by the corporation. Whether or not corporate social responsibility will have any real impact on corporate behaviour is yet to be determined but the evidence to date would suggest not.

The following section will now examine how the behaviour of criminal corporations results in corporate crime.

### 4.4 Corporate Crime

The previous section considered the nature of corporations and why it resulted in criminal corporations, this section will now consider concept of corporate crime which can include deviant behaviour such as corruption, fraud and other financial wrongdoing as well as causing death and injury to members of the public and workers. The focus of this Chapter will be on deaths arising from work activities to both workers and members of the public although it can be difficult to isolate one form of corporate wrongdoing from others.

Cullen et al identified E.A. Ross as one of the first commentators to observe in 1907 what he considered to be the pervasive criminal behaviour carried out by people engaged in major business activities, that is, white collar, or corporate criminality. Slapper and Tombs traced the concepts of corporate criminality to the first half of the nineteenth century and the publication in 1840 of *What is Property? An Inquiry into the Principle of Right and of Government* by Pierre-Joseph Proudhon, whose ideas were further developed as the century progressed by others including Marx and Engels. One example of widespread corporate criminality in the nineteenth century and one of the first subject to specific

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448 Slapper and Tombs, *Corporate Crime* op. cit. n.9, p.2
legislative control was the adulteration and sale of food unfit for human consumption. The deliberate addition of various substances to bulk-up foodstuff, extend shelf-life or change its appearance was done on an industrial scale to maximise profit at the expense of the consumer. Burnett identified food adulteration as a crime of urbanisation becoming more common in the United Kingdom towards the end of the eighteenth century and ubiquitous in the nineteenth. Many staple foodstuffs were adulterated including bread, beer and tea and Burnett referred to an official report from the early part of the nineteenth century which estimated 4,000,000 lbs of curled and dried leaves from English hedgerows were passed-off as ‘tea’ compared to the 6,000,000 lbs of genuine tea imported into the UK by the East India Company. This gives some idea of the scale of the criminality but Burnett went on to suggest that ale and porter were even more prone to adulteration, in some cases with highly toxic and poisonous substances. According to Burnett, the decade between eighteen-forty and eighteen-fifty was the nadir of food adulteration in the UK, at least so far as consumers were concerned. In 1848, Mitchell published his Treatise on Falsifications of Food, and the chemical means employed to detect them in which he discussed the results of his analysis of a range of commonly adulterated foodstuffs. The most basic staple foodstuff at the time was bread which could be adulterated with a range of contaminants including carbonate of ammonia, carbonate of magnesia, chalk, sulphate of copper, sulphate of zinc (both described by Mitchell as “highly poisonous”), bicarbonate and carbonate of potash, plaster of Paris and pipe clay. A common adulterant added to bread was alum (potassium aluminium phosphate) which ‘improved’ poor quality flour allowing it to be used to bake bread that could subsequently be sold as best bread. It also allowed a higher proportion of non-wheat flour to be used further adulterating the bread. In his analysis of various breads, Mitchell did not find a single sample that was not adulterated with alum. It would be 1875 before this type of adulteration was made an offence. Although food adulteration in

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449 E. J. T. Collins, ‘Food adulteration and food safety in Britain in the 19th and early 20th centuries’ (1993) 18 Food Policy 95 95
450 John Burnett, ‘The History of Food Adulteration in Great Britain in the Nineteenth Century, with Special Reference to Bread, Tea and Beer’ (1959) 32 Historical Research 104 105
451 Mitchell, Treatise on the Falsifications of Food, and the Chemical Means to Detect Them op. cit. n.24, p.122
452 Ibid
453 Sale of Food and Drugs Act 1875 (38 & 39 Vict.)
nineteenth century London could be considered outside the main focus of this thesis, it does demonstrate that corporate crime was commonplace across a range of industrial and commercial sectors and would remain so until effective legislation and enforcement mechanisms were introduced to properly control it. This would suggest that corporations and similar organisations have undertaken what could only be described as criminal behaviour since the eighteenth century (and probably prior to that), but it was only in the twentieth century that such activities would be described as corporate or white collar crime. The first use of the term ‘white collar crime’ is generally attributed to Edwin Sutherland (described as the “father of white collar crime” by Lilly et al454), most notably in his book White Collar Crime published in 1949, although he did use the phrase earlier in his 1940 paper, White-Collar Criminality to describe the activities of some of the more notorious employers of the late nineteenth century United States.455 Sutherland described white collar crime as “...a crime committed by a person of respectability and high social status in the course of his occupation” but he did stress that the term itself was not definitive and was intended to describe crimes that would not normally fall under the scope of criminality.456 Sutherland’s description implied that white collar crimes were committed by individuals, either for personal gain or for the benefit of the organisation but the examples of white collar crime he subsequently described arose mainly from the actions of organisations, rather than individuals; as Wheeler pointed out, White Collar Crime “...was devoted... to the crimes of organizations, not of persons...”.457 Tappan was critical of Sutherland’s broad approach to what constituted white collar crime and in particular the widening of the term to include behaviour which although it could be considered antisocial or immoral in some way, or “socially injurious”, was not in itself illegal (see the discussion on the Ford Pinto

454 J. Robert Lilly, Francis T. Cullen and Richard A. Ball, Criminological Theory: Context and Consequences (5th edn, Sage 2011) 269  
456 Ibid 7  
previously in this Chapter). He also commented upon the general vagueness of the term “white collar crime” and the difficulties of the enforcement of legislation dealing with what he called business crimes. Orland described Sutherland’s approach to white collar crime as Marxist, focusing on the socio-economic status of the offender rather than the crime itself, and he also pointed out that Sutherland’s definition of crime went far beyond the accepted legal categories of criminal behaviour in existence at that time. Orland was generally critical of Sutherland’s approach to white collar crime but more as a result of his interpretation of what it was, rather than its existence, indeed, he suggested that “…the gap between recorded and actual corporate crime may be even greater than for other forms of crime.”

As discussed previously, the term “white collar crime” is rather vague and it can apply equally to crimes carried out by individuals at various levels (management rather than shop floor) of an organisation but also crimes carried out by the organisation as an entity (although it could be argued that ultimately an individual or individuals must be responsible for the actions of the organisation). Hartung’s definition of white collar crime, “...a violation of law regulating business, which is committed for a firm by the firm or its agents in the conduct of its business” was much narrower than Sutherland’s but probably more in keeping with the current concept of corporate crime and certainly more applicable to the concept of corporate manslaughter and corporate homicide. Edelhertz followed a similar route defining white collar crime as “...an illegal act or series of illegal acts committed by nonphysical means and by concealment or guile, to obtain money or property, to avoid the payment or loss of money or property, or to obtain business or personal advantage.” This definition is one of the more comprehensive attempts and includes a number of important characteristics of white collar crime including the illegal act or acts, the non-violent nature of the criminal act and obtaining business or personal advantage. The question of whether or not the law must be broken in order for corporate

459 Orland, ‘Reflections on Corporate Crime: Law in Search Theory and Scholarship’ op. cit. n.376, p.505
460 Ibid
crime to be committed is still subject to some debate with Frank and Lynch including “...socially injurious and blameworthy acts, legal or illegal...” in their definition, in some respects following Sutherland’s approach in including a wide range of otherwise legal (or perhaps more accurately, not illegal) activities.\textsuperscript{463} Whilst the desire to include legal, but undesirable, immoral or reprehensible activities in the definition of corporate crime is understandable, it is difficult to see how a crime can be committed if no laws are broken. Gobert and Punch raised the same question and suggested that Sutherland and his followers “...may have been guilty of confusing corporate misconduct which they felt should be criminal...with what was actually proscribed by the law.”\textsuperscript{464} They suggested that this confusion may have arisen because similar misconduct undertaken by an individual would almost certainly have been unlawful and this leads on to a further question of why corporate misconduct has not been criminalised in the way that might have been expected. They answered this question by referring to the influence that powerful corporations have over government policy with significant resources being expended on influencing politicians and law makers. Even where statutory control seems inevitable, Gobert and Punch suggested that it mainly takes the form of regulation, rather than “true” criminal law.\textsuperscript{465} This rather artificial but very important distinction will be discussed in detail in Chapter Six.

The sociology of deviance may explain to some extent the “confusion” attributed to Sutherland by Gobert and Punch discussed above. The concept of deviance and deviant behaviour has been touched upon previously in this Chapter but it is worthy of further exploration. Vaughan defined organisational deviance as “...an event, activity, or circumstance, occurring in and/or produced by a formal organization, that deviates from both formal design goals and normative standards or expectations, either in the act of its occurrence or in its consequences, and produces a suboptimal outcome.”\textsuperscript{466} She went on to suggest that “...much organizational deviance is a routine by-product of


\textsuperscript{464} James Gobert and Maurice Punch, Rethinking Corporate Crime (Butterworths 2003) 10

\textsuperscript{465} Ibid

\textsuperscript{466} Vaughan, ‘The Dark Side of Organizations: Mistake, Misconduct, and Disaster’ op. cit. n.431, p.273
the characteristics of the system itself”, that is, a form of routine non-conformity. Lilly et al described this routine non-conformity in terms of Vaughan’s theory of the “normalization of deviance” going on to describe it as “...a cultural set of beliefs and norms that guides decision making...” that neutralise perceptions of danger. Burns and Orrick included activities by “…elites and management...” in their definition which, although not criminal, are harmful in some way. One advantage of referring to corporate deviance rather than corporate crime is it includes legal (or at least not illegal) as well as illegal activities and starts to address some of the difficulties in labelling corporate activities that are socially unacceptable or otherwise reprehensible but not in themselves unlawful. Whilst the concept of corporate deviance is, in some respects, useful to explain some characteristics of corporate behaviour, it is focussed more on the sociology of that behaviour than its criminality. There is still uncertainty about the nature and form of corporate deviance, whether it includes corporate crime or if it is something different.

Slapper and Tombs described ‘white collar crime’ as criminal activity carried out by individuals (“individually rich or powerful”) within an organisation for their own benefit or furtherance. In this way, they distinguished between white collar crime and the more mundane criminal activities carried out by workers at a much lower level in an organisation for their own financial benefit. In effect, they differentiate between criminal activity carried out by the rich and powerful (white collar crime) and the ordinary workers (straightforward crime) even though the criminal activity may be carried out in the same organisation for the same ultimate purpose, namely personal benefit. They then differentiated between white collar crime and corporate crime by describing the latter as criminal activity or illegality with the intention of meeting or furthering an organisation’s goals rather than directly benefiting an individual, supporting McMullan’s view that corporate crimes were committed for the organisation, not against it. Proposing it as a subset of white collar crime, Gruner described...
corporate crime as “...crime undertaken in corporate business activities...” usually committed for the benefit of the organisation but he also included actions by individuals for personal benefit or to avoid negative consequences of their failure.\(^{472}\) There is very little difference between Gruner’s definition of corporate crime and the widely accepted definition of white collar crime; including actions by individuals for their own personal benefit blurs the distinction between white collar and corporate crime. Whilst it is attractive to include corporate wrongdoing which is lawful but morally and socially reprehensible, for the purposes of this thesis, corporate and white collar crime will be assumed to be criminal, that is, involving unlawful activities. This approach mirrors that of Slapper and Tombs who also implied some regret that corporate crime cannot be extended to include what they refer to as social harms.\(^{473}\) This approach fits with most of the accepted definitions of corporate crime and will form the basis for the subsequent discussion on corporate criminality. Describing their work as “...the first large-scale comprehensive investigation of corporations directly related to their violations of law...”, Clinard et al suggested that the cost of corporate crime ran into billions of dollars each year, giving some idea of the scale of the problem in the US at that time.\(^{474}\) It is unlikely that the cost of corporate crime has come down since Clinard et al’s report, indeed following the worldwide financial collapse of the banking system in 2008, it is likely that the costs of corporate crime would have run to hundreds of billions of dollars.

At least part of the explanation for corporate criminality can be found in the origins and nature of incorporation discussed previously in this Chapter, in particular the direction taken towards the end of the nineteenth century which saw an increasing emphasis on the corporation for the benefit of the owners (shareholders) rather than society more generally. This has been interpreted as profit above all else and although most corporations do not deliberately undertake unlawful activities, their behaviour can be morally and socially reprehensible, lawful or otherwise. This is best illustrated by Kagan and Sholz who suggested that the most widely accepted model of corporate

\(^{472}\) Richard S. Gruner, *Corporate Criminal Liability and Prevention* (ALM Publishing 2004) 1
\(^{473}\) Slapper and Tombs, *Corporate Crime* op. cit. n.9, p.19
\(^{474}\) M.B. Clinard and others, *Illegal Corporate Behaviour*, 1979) abstract; ibid
criminality presented the corporation “...as an amoral, profit-seeking organization whose actions are motivated wholly by rational calculation of costs and opportunities.” Unlawful behaviour can be deliberately undertaken by corporations but it is frequently the consequence of incompetence, carelessness or thoughtlessness, encouraged by the nature and structure of corporations discussed previously in this section. It should also be recognised that not every organisation associated with corporate crime or misconduct of the type described previously is a corporation but they do tend to share at least some of the characteristics associated with them. One characteristic of corporate crime is any investigation will primarily focus on whether or not a crime has been committed rather than who did it.

Gobert and Punch took a fairly sophisticated approach to corporate criminality, suggesting in the first instances that there is no single causal explanation for it, arguing that if it was only about the pursuit of profit or other benefit to the company, then all companies would be inclined to criminality all of the time rather than just some and then only on occasion. There is some debate about the extent of criminality by corporations and Gobert and Punch assumed that not all companies were engaged in criminal behaviour although as discussed previously in this Chapter, Carson’s research into Factories Acts’ contraventions indicated almost ubiquitous non-compliance. To determine the extent of corporate crime, Slapper and Tombs reviewed a range of published work based on both quantitative and qualitative approaches starting with Sutherland’s work and concluded that corporate crime “...results from almost every business activity, in almost every area of economic activity, amongst corporations and organisations of all sizes.”

Gobert and Punch identified five variables that can contribute to corporate criminality although they suggested that there may be other reasons why some corporations engage in criminality. The five ‘key’ variables identified include social, economic and cultural factors; the nature and structure of organisations;

475 Kagan and Scholz, ‘The “Criminology of the Corporation” and Regulatory Enforcement Strategies’ op. cit. n.405, p.356
476 ‘Corporate Crime: Regulating Corporate Behavior through Criminal Sanctions’ op. cit. n.13, p.1227
477 Gobert and Punch, *Rethinking Corporate Crime* op. cit. n.464, p.15
478 Slapper and Tombs, *Corporate Crime* op. cit. n.9, p.50
479 Gobert and Punch, *Rethinking Corporate Crime* op. cit. n.464, p.15
intent, rationality and competence; defence mechanisms and techniques of
dissociation; crime facilitative and crime coercive industries. This approach
resulted in a much more complex explanation for corporate criminality which
extended beyond the desire just to maximise profit and shareholder return or to
avoid the consequences of previous questionable behaviour and they emphasise
that although the corporation may provide the opportunity and mechanism for
crime to be committed, the role of the individual must not be ignored. Clinard
et al emphasised the importance of individuals when describing corporate crime
as a form of white collar crime “...but it is white collar crime of a particular
type. Actually it is organizational crime that occurs in the context of extremely
complex and varied sets of structured relationships, and inter-relationships
between boards of directors, executives, and managers on the one hand and
parent corporation, corporate divisions and subsidiaries on the other.”

This view of corporate crime is mirrored by the Harvard Law Review which stated
that corporate crime “…typically involves the concerted action of several
individuals within the corporation, so an investigation or prosecution will likely
implicate them as well as the corporation itself.”

Although much of this Chapter has been devoted to discussing the corporation as
an entity, it must be recognised that it is not a living person and in itself, it does
not have the ability to develop and implement strategy and make decisions;
these must be undertaken by its employees, directors or executives,
shareholders, customers or any other stakeholder. Where the actions of an
individual or individuals results in unlawful activity which benefits the
corporation, it is right and proper that the corporation is properly punished but
depending upon the circumstances, it must also be equally right and proper
those individuals are also considered for appropriate punishment if their acts of
omission or commission are responsible for the unlawful acts. The relationship
between the corporation guilty of committing a criminal act and the individuals
responsible for circumstances leading to that act will be discussed in more detail
in in the next Chapter.

480 Clinard and others, *Illegal Corporate Behaviour* op. cit. n.474, p.xii
481 ‘Corporate Crime: Regulating Corporate Behavior through Criminal Sanctions’ op. cit. n.13,
p.1293
While considered ubiquitous by some commentators, the true extent of corporate crime is not known with any certainty but it would appear to be endemic in some sectors. There has been an almost continuous litany over the past thirty or forty years of scandals in the banking and financial sectors, most recently including the mis-selling of PPI, market manipulation (LIBOR, FOREX), money laundering, bribery and tax evasion to name but a few. It is not just the banking and financial sectors that are guilty of law breaking on a major scale, in 2015 the Volkswagen Group admitted installing software in eleven million vehicles to cheat emissions testing procedures, an action both illegal and morally reprehensible. Many of these scandals arose through straightforward law breaking; there was no confusion or ambiguity about the requirements of the law which would suggest that if there is a benefit to criminal activities (most likely increased profits), then the crimes will be committed (although it could be assumed that the perpetrators acted on the basis that their crimes would probably not be detected). There is no reason to suspect that other sectors are any less likely to willingly participate in criminal activity, if there is a benefit to it and the chances of being caught are considered small.

4.5 Corporate Killing as Crime

Corporate crime covers a wide range of illegal activities but the remainder of this chapter will focus on one particular category – corporate killing. Perhaps the most obvious manifestation of corporate killing arises from workplace accidents and exposure to various substances whilst at work. The International Labour Organisation estimated that approximately 2.3 million people worldwide die each year from accidents, disease or illness as a consequence of being at work. In Great Britain, with its long history of workplace safety legislation and enforcement, 133 fatal injuries to workers were recorded for 2013/14 (these figures do not include fatal injuries to members of the public and others caused

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by work activities and Northern Ireland is excluded). Much more difficult to collect is data on deaths arising from work related disease and illness but the Health and Safety Executive estimated that in Great Britain in 2013/14, around 13000 people died from respiratory illness and cancer caused mainly through exposure to chemicals and dust. It must be assumed that many more workers die as a consequence of illness or disease acquired through workplace exposure to various substances and activities. These figures also exclude members of the public and others who may have died as a consequence of work activities. There is a danger that corporate killing is seen as something that happens to workers but it must be viewed as something much wider than that. The people killed as passengers or drivers of Ford Pintos discussed previously in this chapter were just as much victims of corporate killing as workers killed through the negligence or connivance of their employers so when considering what is meant by corporate killing, it is important to include all those killed as a consequence of corporate crime, not just workers.

It can safely be assumed that deaths arising from corporate activities have occurred for as long as corporations and other institutions have existed. The term corporate killing can include deaths from a wide range of activities including the sale of adulterated food and medicines, counterfeit and sub-standard engineering parts and equipment, operation of unsafe aircraft and vessels, poor maintenance and servicing, and so on. While all of these activities have resulted in deaths that can be directly attributed to the activities of corporations, the rest of this Chapter will focus on those fatalities, both to workers and others, that have arisen directly as a result of work activities.

The possibility of being killed or suffering a fatal illness or diseases as a consequence of work activities has been ever-present since the concept of work first existed but industrialisation in the nineteenth century made it much more likely and also more likely to affect a wider range of people, including children and women. In many cases, these work related fatalities were considered a part of working life with compensation sometimes, but not always, being paid to the victim’s family following an industrial accident. The widespread acceptance of

485 Ibid
death as a consequence of work activities in the nineteenth century is demonstrated by the prosecution of Bryant and May in 1898 following the identification of seventeen cases of phosphorous poisoning resulting in six deaths, mainly (but not only) of women and girl workers who were collectively known as the “match girls”.\textsuperscript{486} In 1898, Bryant and May were prosecuted for failing to notify the appropriate authorities following the discovery of cases of necrosis caused by exposure to white phosphorous. It is important to emphasise that the prosecution was not because of the disease, or even the deaths arising from it, but as a consequence of failing to notify the appropriate authorities of the cases. The reason that the Bryant and May case is worthy of note is that it received significant press coverage at the time and there was a national outcry following the disclosure of the working conditions and dangers faced by the match girls and other workers in that industry. This is just one of many thousands of cases of death arising from work activities but it shows how little regard was held for human life, not just by employers but also the State and, to a lesser extent, the trades unions. It is fair to say that the emphasis in the nineteenth and twentieth centuries was the payment of compensation following workplace deaths and disease rather than punishing the employer for allowing them to happen.

The attitude to deaths arising from work activities started to change following the Aberfan disaster discussed in Chapter Two, although the emphasis at that time was on preventing its recurrence rather than punishing the employer; there was no suggestion that the National Coal Board or its officers would be considered criminally responsible for the deaths that occurred as a consequence of their negligence. The concept of punishment where employers or companies were considered responsible for the deaths started to gain momentum following a number of high profile accidents that occurred towards the end of the twentieth century. The nineteen-eighties and -nineties saw a number of multi-fatality, high profile accidents in the UK, including the Bradford City Fire in 1985; the Herald of Free Enterprise capsize and Kings Cross fire in 1987; the Piper Alpha explosion and the Clapham rail crash in 1988; the Hillsborough disaster and the sinking of the Marchioness in 1989; the Southall rail crash in

\textsuperscript{486} Lowell J. Satre, ‘After the Match Girls’ Strike: Bryant and May in the 1890s’ (1982) 26 Victorian Studies 7 24
1997; the Ladbroke rail crash and the Larkhall gas explosion in 1999 and the Hatfield train derailment in 2000. This is by no means an exhaustive list of the disasters that occurred during that period but it does include those mainly responsible for the rising public dissatisfaction with the legal response to this type of event. Some of these cases will be discussed in more detail in the next Chapter but they are all notable in that there was either no prosecution for corporate manslaughter or if there was, it failed in some way, although it should be noted that prosecution for health and safety offences often succeeded where a manslaughter prosecution failed or was not undertaken. During the period in question, there was a small number successful corporate manslaughter prosecutions and the most notable of these will also be discussed in the next Chapter.

The idea that an organisation or corporation in England and Wales can commit manslaughter is not new and the historical development of the offence of corporate manslaughter (and corporate homicide in Scotland) will be discussed in more detail in this and the next Chapter. Wells pointed out that the Interpretation Act 1889 (“...the expression ‘person’ shall, unless the contrary intention appears, include a body corporate”\(^487\)) and case law had established that corporations could be both directly and vicariously liable for many criminal offences.\(^488\) In *Mousell Brothers, Limited v London and North-Western Railway Company*, Disturnal and Wingate-Saul argued that a “...body corporate can only act through its officers and servants. The act and intention of its officer are the act and intention of the corporation.”\(^489\) Although this statement was not subsequently referred to in the judgement in *Mousell*, it did reappear in *R. v ICR Haulage*, one of the leading cases in establishing criminal liability of corporations.\(^490\) In this case, which involved fraud, it was held that “... the acts of the managing director were the acts of the company and the fraud of that person was the fraud of the company...”.\(^491\) Although this judgement would apply to most criminal offences, there are specific types that cannot be committed by a corporation due to their “...very personal nature...”, for example, perjury,

\(^{487}\) The Interpretation Act 1889 (52 & 53 Vict. c 63)S.2  
\(^{488}\) Wells, *Negotiating Tragedy: Law and Disasters* op. cit. n.168, p.163  
\(^{489}\) *Mousell Brothers, Limited v London and North-Western Railway Company* [1917] 2 KB 836 (King’s Bench Division) 842  
\(^{490}\) *R v I.C.R. Haulage, Limited and Others.* [1944] KB 551 (Court of Criminal Appeal) 553  
\(^{491}\) Ibid
bigamy, murder and various sexual offences, in effect, “...by their very nature can only be committed by a natural person...”.

This case established that manslaughter or culpable homicide could be committed by a corporation and, as will be discussed in the next Chapter, successful prosecutions for manslaughter were brought against corporations, but in very restricted circumstances as a consequence of *Tesco v Nattrass*. The importance of *Tesco v Nattrass* in subsequent prosecutions of corporations for manslaughter (and other criminal offences) cannot be overstated and in many respects is one of the main reasons why the law dealing with corporate killing was considered inadequate. *Tesco v Nattrass* will be discussed in more detail in the next Chapter.

### 4.6 Conclusion

Corporations are a ubiquitous part of twenty-first century society and it is difficult to imagine any part of life they do not impact upon in one way or another. There are many advantages to incorporation for owners (and shareholders), perhaps the most beneficial being limited liability, but this is not its only significant characteristic. Although not human, corporations do have a legal personality which also affords them particular advantages but without the moral and legal responsibilities that a human personality must adhere to. Transferable shares, centralised management and shared ownership complete the picture of what a corporation is but the emphasis on it as a vehicle to maximise shareholder return is one of the further characteristics most often associated with corporate crime. All of these characteristics contribute to the apparent widespread criminality associated with corporations. Whether or not corporations can be guilty of committing various types of crime has been subject to much debate but case law in the twentieth century has clearly established that their behaviour can be criminal in most circumstances. The only crimes that corporations cannot commit are those that require a very specific type of human involvement, such as bigamy, perjury and crimes of a sexual nature.

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492 R. v P & O European Ferries (Dover) Ltd. op. cit. n.6, p.1; The Law Commission, *Law Commission Consultation Paper No 135, Involuntary Manslaughter (LCCP 135)* op. cit. n.4, p.19
Corporate crime (for the benefit of the organisation, rather than the individuals within it, although they may also benefit) has a long and ignoble history with the evidence suggesting that corporations and other organisations frequently participate in criminal behaviour as a matter of normal business practice. Corporate crime is often associated with financial and economic activity but can include environmental and safety violations. A number of theories have been put forward to explain criminality by organisations but none of them are able to do so entirely and it is likely that only by combining the various theories can it be properly understood. Some commentators have linked size with criminality, arguing that corporate wrongdoing is associated with the very largest companies but there is no evidence that they are more likely to commit crime than the smallest. Where size does count is in the likelihood of being caught and convicted; small organisations are more likely to be found guilty of an offence as a consequence of the identification doctrine. The late twentieth and early twenty-first centuries saw corporate killing confirmed as both a possible consequence of corporate activity and a crime in its own right, albeit one that was very difficult to prove in court for the reasons explained in the next chapter where the development of corporate killing into the offence of corporate manslaughter/corporate homicide will be examined.
5.0 The Corporate Manslaughter and Corporate Homicide Act 2007

5.1 Introduction

In 1969 a prosecution was brought against Tesco Supermarkets Ltd in respect of a contravention of the Trade Descriptions Act 1968 following an advertisement posted in the window of a Tesco branch for an offer on soap powder that was not available in the store.\textsuperscript{494} Tesco was convicted but appealed to the Divisional Court which also found against it, but did not agree entirely with the decision of the Justices in the original case. Tesco further appealed to the House of Lords where their appeal was upheld. The basic question addressed in this case was whether or not the manager of the store was “...acting as the company and his mind which directs his act is the mind of the company.”\textsuperscript{495} Amongst the many cases referred to in \textit{Tesco v Nattrass}, Denning, LJ’s comments in \textit{H.L. Bolton (Engineering) Co. Ltd. v. T.J. Graham & Sons Ltd.} are particularly important, “Some of the people in the company are mere servants and agents who are nothing more than hands to do the work and cannot be said to represent the mind or will. Others are directors and managers who represent the directing mind and will of the company, and control what it does. The state of mind of these managers is the state of mind of the company and is treated by the law as such”. The view that there are some people in an organisation who represent its “directing mind and will” whilst others do not has had a significant influence in the success or failure of any prosecution for corporate manslaughter.

Returning to \textit{Tesco v Nattrass}, Pearson, LJ supported the view that “...some officers of a company who may for some purposes be identified with it, as being or having its directing mind and will, its centre and ego, and its brains.”\textsuperscript{496} Pearson went on to suggest that the directing mind or ego of the company (Tesco in this case) could only be vested in a person at a senior level in the company responsible for “...managing the affairs of the company...”. Diplock, LJ took the view that determining the natural persons who are to be treated in law

\textsuperscript{494} Ibid
\textsuperscript{495} Ibid
\textsuperscript{496} Ibid
as the company would be done by reference to the articles of association of the company and that the negligence of any such natural person would be taken to be negligence of the company itself. In most circumstances, the natural persons referred to by Diplock would include company directors, company secretaries and senior managers but this could vary from company to company.497

As stated previously, Tesco v Nattrass had a significant influence on subsequent prosecutions of companies and corporations and, as would be expected, has been subject to much commentary and has become known as the “identification doctrine”, that is, the identification of the person or persons “...whose state of mind would constitute the state of mind of the corporation” and whose actions could be considered the actions of the company.498 At its simplest, this would be the person or persons who issued instructions, rather than received them.499 This means that for a corporation to be guilty of manslaughter, one or more of its directors or most senior managers must also be guilty of manslaughter.500 One of the consequence of this interpretation of corporate liability was the introduction of a two tier justice system, with the largest corporations effectively being immune from prosecution for manslaughter but a very different possible outcome for the smaller organisations where the senior management was closer to the day-to-day decision making process.

According to Wells, the decision reached in Tesco v. Nattrass resulted in “...interpretive absurdities...”501 while Burles suggested that while it was logical, it was not necessarily sensible.502 In a rather critical commentary of the depth of knowledge of large corporations demonstrated by their Lordships in reaching their decision, Parsons suggested that the identification doctrine existed “...as a legal barrier to potential corporate criminal liability and this arises from their Lordships' dated (even for 1971) understanding of the way large corporations operate.” Almond pointed out that while the interpretation of the controlling or directing mind provides a “...degree of doctrinal certainty, it also severely

497 Wells, Negotiating Tragedy: Law and Disasters op. cit. n.168, p.165
499 Steve Tombs and Dave Whyte, Safety Crimes (Willan Publishing 2007) op. cit. n.9, p.131
501 Wells, Negotiating Tragedy: Law and Disasters op. cit. n.168, p.165
502 Burles, ‘The criminal liability of corporations’ op. cit. n.500, p.611
restricts the capacity of the law to hold corporate bodies liable for criminal offences.” The consequences of this restriction in holding corporate bodies liable for criminal offences, and in particular manslaughter or culpable homicide will now be explored in more detail since it led to the circumstances responsible for the popular clamour “for something to be done”. That “something” resulted in the Corporate Manslaughter and Corporate Homicide Act 2007.

The concept of corporations and corporate crime was discussed at length in the previous Chapter and it is clear that there was a great deal of uncertainty and ambiguity in respect of the liability of corporations in the event of deaths arising from their activities. This had led to the general consensus that while a corporation could be prosecuted for manslaughter, there would be a number of barriers in the way of any such prosecution being successful. A number of major accidents in the late twentieth and early twenty-first centuries demonstrated just how difficult prosecuting large corporations would be, even where there was clear evidence of gross negligence. The first part of this Chapter will focus on the actual or perceived inability of the law to punish large corporations for their apparent failures that subsequently resulted in major loss of life, starting with the fifty-six fatalities arising from the Bradford City Stadium Fire in May, 1985 before moving on to examine a number of other accidents with a major loss of life that took place over the following fifteen years or so.

What all these incidents had in common was the perceived failure of the health and safety legislation to effectively punish the corporations considered responsible for the accidents and the deaths arising from them. The Government’s response was to review the law of manslaughter to consider how it could be extended to include deaths caused by work or work activities. One of the main stumbling blocks in the few unsuccessful corporate manslaughter prosecutions attempted in the years since the Bradford Fire was the difficulty in satisfying the ‘identification doctrine’, in effect the need to identify an individual at senior level who could be considered directly responsible for the accident. The difficulties encountered with the identification doctrine will be

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503 Paul Almond, Corporate Manslaughter and Regulatory Reform (Crime Prevention and Security Management, Palgrave Macmillan 2013)
discussed at length in the following sections but to all intents and purposes, it made the prosecution of large corporations for manslaughter all but impossible.

It was almost fifteen years before the Government’s various consultations resulted in the Corporate Manslaughter and Corporate Homicide Act 2007. Whilst this Act does address, to some extent, the main barriers to successful corporate manslaughter prosecutions, it did introduce a raft of other issues that perhaps made it more difficult than it should be to prosecute the very largest companies for manslaughter. These issues will be analysed and discussed towards the end of this Chapter.

5.2 The Disasters

The Bradford City Stadium Fire in May, 1985, which resulted in fifty-six deaths, was the first disaster with a major loss of life where the behaviour of the organisation responsible for the operation of the stadium and consequently, the fire that resulted in the deaths, was called into question. Investigators concluded that the fire was initially started by discarded smoking materials falling through the stand onto an accumulation of combustible wastes. The fire quickly took hold and spread rapidly through the stand. Escape was difficult due to inadequate fire exits to the rear of the stand. The stadium did not meet the relevant standards laid down in guidance, and previous warnings had been given in respect of the accumulation of combustible materials below the stand but, perhaps surprisingly, there seemed to be no discussion of prosecution of the stadium owners for manslaughter, nor was there a prosecution taken by the Health and Safety Executive. Hopwood and Adams suggested that the Bradford City Fire signalled the start of the concern over the lack of accountability of large organisations in the event of major accidents. Although that view would appear not to be supported by lack of action by the

505 Mr Justice Popplewell, *Committee of Inquiry into Crowd Safety and Control at Sports Grounds. Interim Report* (Cmd 9585, 1985)
Health and Safety Executive or any other public authority, the widow of one of the victims and a police officer took an action against the club, the Health and Safety Executive and the County Council.\(^{507}\) The case against the Health and Safety Executive was dismissed but it was held that the club was two-thirds responsible for the fire and the County Council one-third responsible, leading the way for compensation to be paid to the survivors and victims’ families. In a newspaper article twenty-five years after the fire, the coroner, James Turnbull, revealed that he had considered directing the jury to a manslaughter verdict, rather than the death by misadventure that was eventually recorded.\(^{508}\) His reason for not doing so was the difficulty in attributing liability to a corporate body.

The next major disaster in the UK with multiple fatalities changed everything. On the 6\(^{th}\) March, 1987 the roll-on, roll-off ferry, the Herald of Free Enterprise operated by Townsend Car Ferries Limited capsized with the loss of one-hundred and eighty-eight lives (the number of deaths varies slightly from source to source but this is the number cited in the Report of Court) shortly after setting sail from Zeebrugge to Dover.\(^{509}\) The immediate cause of the accident was ingress of a large volume of water through the open bow door causing the vessel to capsize shortly after leaving its berth. The Report of Court identified a number of failures in the operation of the vessel, including the assistant bosun responsible for ensuring the bow doors were properly closed sleeping through the muster call and the captain setting sail without confirming that the vessel was in a safe condition but it also identified significant failings of the management of the Company, “...leads inexorably to the conclusion that the underlying or cardinal faults lay higher up in the Company.”\(^{510}\) In the same section, the report went on to say “From top to bottom the body corporate was infected with the disease of sloppiness...”, a clear indication that the Company, as an entity, had failed in its duty to protect the safety of both employees and passengers. Unlike the Bradford City Fire, subsequent charges for manslaughter were laid against both

\(^{507}\) Fletcher and Others v Bradford City Football Club and Others Leeds, 23rd February 1987 (Queen’s Bench Division)
\(^{509}\) Mr Justice Sheen, mv HERALD OF FREE ENTERPRISE. Report of Court No. 8074 (Department of Transport, 1987) 1
\(^{510}\) Ibid
the Company and a number of named individuals who were considered directly accountable for the events leading up to the capsize of the vessel and the subsequent loss of life.

There would appear to be no significant differences between the Bradford City Fire in 1985 and the Herald of Free Enterprise capsize in 1987, both had a significant loss of life that was directly attributed, at least in part, to the behaviour of the senior management, but there was clearly a major change in the public reaction. The damming Report of Court discussed previously placed the blame for the accident squarely on the company and that report was followed by the Coroner’s Inquest where the jury returned a verdict of unlawful killing. In his decision, the Coroner made a number of statements that seemed to contradict previous case law; in his opinion there was no case of manslaughter against any of the five individuals who had been named in the inquest as being directly responsible for the accident, a company could not, in law, be indicted for manslaughter, and even if such a charge was possible, there was no evidence that would support it, and finally, a charge of manslaughter could not be found on the aggregation of a number of individual acts that in themselves did not constitute gross negligence.511 As a consequence of these conclusions, relatives of the victims sought leave to seek judicial review on the grounds that the Coroner misdirected the inquest jury. Although the request was refused, it was established that a company could be guilty of manslaughter, given the appropriate circumstances, a view confirmed by Turner, J. in R v P & O European Ferries Ltd.512

On the basis of the verdict of the Coroner’s Inquest jury and the subsequent confirmation by Turner, J. and others that a corporation could be found guilty of manslaughter, the Director of Public Prosecutions charged seven individuals (including two company directors) and the company (Townsend Thoresen was acquired by P & O shortly after the accident consequently acquiring liability).513 Before the prosecution had finished presenting its case, the judge dismissed the charges against both company directors which, on the basis of the identification doctrine, meant that the charges against the company also had to be

511 R. v H.M. Coroner for East Kent (1989) 88 Cr App R 10 (Queen’s Bench (Divisional Court)) 16
512 Ibid, R. v P & O European Ferries (Dover) Ltd. op. cit. n.6, p.74
513 R. v Alcindor and others Unreported (Central Criminal Court)
dismissed.\textsuperscript{514} The Director of Public Prosecutions then withdrew the charges against the remaining 5 defendants. The Herald of Free Enterprise disaster resulted in extensive discussion and debate amongst legal, transport and safety experts but the general consensus was that the various court hearings resulted in two major outcomes; corporations could be found guilty of manslaughter but given the application of the identification doctrine, it be extremely unlikely ever to happen.\textsuperscript{515} The principle of the identification doctrine established in \textit{Tesco v. Nattrans} effectively prevented corporate manslaughter actions against any but the very smallest organisations. Without the identification of a senior manager who could hold directly responsible for the deaths, it would be impossible to find against the company. Although he would be subsequently proved wrong (for reasons discussed later in this Chapter) Slapper suggested that it would be “...virtually impossible for a company to be convicted for manslaughter.”\textsuperscript{516}

The nineteen-eighties would see further incidents which resulted in a major loss of life with subsequent inquiries indicating significant failures of the companies or corporations involved but no consequent corporate manslaughter prosecutions. Following the King’s Cross Fire in 1987 with the loss of thirty-one lives, Desmond Fennel summarised that although he found that the London Underground management considered fires were inevitable, in his view “...they were fundamentally in error in their approach.”\textsuperscript{517} The Cullen Inquiry into the fire on Piper Alpha Platform in 1988, which resulted in the loss of one-hundred and sixty-five men on the platform and two rescue workers, identified “…significant flaws in the quality of Occidental’s management of safety which affected the circumstances of the events of the disaster.”\textsuperscript{518} The report went on to point out that the company “…adopted a superficial response when issues of

\textsuperscript{514} Slapper and Tombs, \textit{Corporate Crime} op. cit. n.9, p.104
\textsuperscript{516} Slapper, ‘Corporate Manslaughter: an Examination of the Determinants of Prosecutorial Policy’ op. cit. n.9, p.437
\textsuperscript{517} Fennell, \textit{Investigation into the King’s Cross Underground Fire} op. cit. n.235, p.17
\textsuperscript{518} The Hon Lord Cullen, \textit{The Public Inquiry into the Piper Alpha Disaster. VOLUME ONE} (Cmd 1310 London:HMSO, 1990) 238
safety were raised by others” as well as other, more specific, shortcomings exhibited by the company.

In December 1988, a train collision at Clapham resulted in the loss of thirty-five lives with a further five-hundred injuries.519 The immediate cause was a signal failure arising from bad wiring practice but the Hidden Inquiry identified failures at nearly every level of the train and track operator, British Railways. Hidden described them as “...faults that are inherent in the way the railway has been run for a number of years. They are many and they must be pointed out”.520

As can be seen from this relatively small sample of accidents, even where there was evidence of significant management failure, there seemed to be no appetite to embark upon a prosecution against any of the perpetrators for corporate manslaughter although the principle had already been well established. The difficulty of prosecuting large corporations for manslaughter was further demonstrated by the prosecutions taken following the Southall and Hatfield train crashes in 1997 and 2000 respectively, and the case against Transco following a gas explosion at Larkhall in 1999. In the Southall case, a train operated by Great Western Railway passed a series of warning signals, including one at red, before colliding with another train resulting in seven deaths. The two main warning devices in the cab were either disengaged or not working properly, facts that were known to the driver who had been distracted when the trains passed through the warning signals.521 In R v Great Western Railways Ltd, Scott Baker, J dismissed seven counts of manslaughter against the company on the basis of the identification doctrine.522 The Attorney-General subsequently referred the case to the Court of Appeal requesting its opinion on two questions, one being could a corporation be found guilty of gross negligence manslaughter without a human individual in the corporation being guilty of the same offence. The clear and unambiguous answer to that question was no, “...the identification principle remains the only basis in common law for corporate liability for gross negligence manslaughter.”523 A similar outcome was experienced in the Hatfield Train

519 Anthony Hidden, Investigation into the Clapham Junction Railway Accident, 1989) 1
520 Ibid
521 Attorney-General's Reference (No. 2 of 1999) [2000] 2 Cr App R 207 (Court of Appeal) 209
522 R v Great Western Railways Ltd Unreported (Central Criminal Court)
523 Attorney-General's Reference (No. 2 of 1999) op. cit. n.521, p.219
Crash where the manslaughter charges against the company and the company directors were dismissed by the judge.\textsuperscript{524}

One of the final attempts at prosecuting a large organisation for corporate manslaughter prior to the introduction of the Corporate Manslaughter and Corporate Homicide Act 2007 was in respect of the gas explosion in Larkhall in 1999 that resulted in the deaths of four members of the same family.\textsuperscript{525} What makes this case different to those discussed previously is that it fell within the Scottish legal system and this was certainly a consideration in the subsequent prosecution. The gas transporting company, Transco, which was responsible for the maintenance of the gas pipeline and accordingly held responsible for the leak that subsequently led to the explosion, appealed against the refusal of the trial judge to dismiss the charge of culpable homicide. Their appeal was based on the argument that “...under the existing law of Scotland, a non-natural person could not in any circumstances be guilty of the common law crime of culpable homicide...”\textsuperscript{526} Importantly, and different to the cases discussed previously, the Crown’s case for corporate culpable homicide was based on a series of decisions made by a number of committees with delegated responsibility; no individuals were identified as being directly responsible for the decisions made leading to the accident.\textsuperscript{527}

In upholding the appeal, the Court agreed that while a corporation can be guilty of culpable homicide, the Crown’s case (“...fatally flawed...”\textsuperscript{528}) failed to show that the actions of individuals or groups of individuals acting as the corporation demonstrated the necessary state of mind amounting to the level of culpability required for a guilty verdict to be returned. Making reference to Tesco v. Nattrass, it was held that the requirements of the identification doctrine had not been met by the Crown. In the same judgement, a significant distinction was drawn between the crime of manslaughter in England and the crime of culpable homicide in Scotland, with the latter requiring \textit{mens rea} to be

\textsuperscript{524} \textit{R v Balfour Beatty Rail Infrastructure Services Ltd} [2006] EWCA Crim 1586 (Court of Appeal)
\textsuperscript{525} Clark and Langsford, ‘A re\-birth of corporate killing? Lessons from America in a new law for Scotland’ op. cit. n.515, p.29
\textsuperscript{526} \textit{Transco Plc v HM Advocate (No.1)} op. cit. n340
\textsuperscript{528} Clark and Langsford, ‘A re\-birth of corporate killing? Lessons from America in a new law for Scotland’ op. cit. n.515, p.30
demonstrated, which was not necessarily the case in England.\textsuperscript{529} Described twice by Lord Osborne in his judgement as “valiant”, the Crown’s case, although unsuccessful, would appear to have had some merit and it did raise the profile of the corporate homicide debate in Scotland and was instrumental in the creation of an expert review group to examine the issue.\textsuperscript{530} The report of the expert group will be discussed in more detail later in this Chapter.

These failed attempts at prosecution for corporate manslaughter would appear to support Slapper’s view discussed previously that it would be virtually impossible to prosecute a company for corporate manslaughter but \textit{R v Kite, Stoddard and OLL Ltd} in 1994 showed that was not quite true. Following the deaths of four children who were on a canoeing trip organised by OLL Ltd, the company, its managing director (Kite) and the centre manager (Stoddard) were each charged with four counts of manslaughter.\textsuperscript{531} Kite was found guilty of individual manslaughter and given a prison sentence of three years (reduced to two years on appeal) and OLL Ltd made legal history in the United Kingdom as the first company to be found guilty of corporate manslaughter (at common law) and was fined £60 000. The jury failed to reach a decision in respect of Stoddard and the case against him was dropped.

The main difference between OLL Ltd and the other cases discussed previously in this Chapter was quite simply the size of the company. OLL Ltd was a very small company employing few people and Kite had day-to-day involvement in management and operational issues and although he was not immediately responsible for the accident, he had been warned of the inadequacies of the systems in place prior to it and had failed to comply with the British Canoe Union guidelines. His role as “directing mind” was easily established and the jury concluded that he was grossly negligent in his actions. That being the case, it was relatively straightforward to also find OLL Ltd guilty of corporate manslaughter but as Wells pointed out, there was little benefit to prosecuting OLL Ltd in addition to Kite since it was a company that very few people had

\textsuperscript{529} P.W. Ferguson, ‘Corporate Culpable Homicide’ (2004) Scots Law Times 4
\textsuperscript{530} Johnson, ‘Ten contentions of corporate manslaughter legislation: Public policy and the legal response to workplace accidents’ op. cit. n.515, p.364
\textsuperscript{531} Lin Jenkins and Frances Gibb, ‘Canoe centre chief and company are found guilty - Lyme Bay conoeing disaster’ \textit{The Times} (London December 9, 1994) 1: Michael Welham, \textit{Corporate Manslaughter and Corporate Homicide: A Manager's Guide to Legal Compliance} (Second edn, Tottel Publishing 2008) 54
heard of before the case and would only survive following the guilty verdict as an historical footnote.\textsuperscript{532} In this respect, it could be argued that the corporate manslaughter verdict in respect of OLL Ltd was symbolic rather than substantive; it was a very small company, operating in a quite specialist sector, whose only claim to fame (or infamy) was to be the confirmation of an already well-established legal principle, that is, a corporation can, under certain circumstances, be guilty of manslaughter.

Although it could not be described as opening the floodgates, \textit{R v Kite and OLL Ltd} was the first of a handful of successful corporate manslaughter cases taken against small organisations where the “directing mind” was easily identified and directly associated with the company. Large companies, irrespective of their nature, were to all intents and purposes immune to prosecution for manslaughter as a consequence of the difficulty in establishing a directing (or controlling) mind responsible for the actions held directly responsible for the death or deaths.\textsuperscript{533} There must be some question about the benefit from prosecuting these very small companies, they employed few people and had a relatively insignificant impact on the attitudes and culture of the large, multinational corporations, but perhaps more importantly, it was patently unfair. The size of the organisation had become the determining factor for the success or failure of a prosecution for corporate manslaughter and this inevitably had an influence on the relevant government law officers when determining the most appropriate course of action in the event of a fatality or multiple fatalities arising out of work activities.\textsuperscript{534}

This state of affairs led to pressure for ‘something to be done’ to address the apparent inadequacies of the legislation to punish corporations considered responsible for fatalities arising from their activities which eventually resulted in the Corporate Manslaughter and Corporate Homicide Act of 2007. Before discussing the 2007 Act in more detail, it is necessary to consider the changing nature of the manslaughter or culpable homicide offence. The use of the terms

\textsuperscript{532} C. Wells, ‘Corporate Killing’ (1997) 147 New Law Journal 1467 1468
\textsuperscript{533} Ibid; Clark and Langsford, ‘A re-birth of corporate killing? Lessons from America in a new law for Scotland’ op. cit. n.515, p.31; Welham, \textit{Corporate Manslaughter and Corporate Homicide: A Manager’s Guide to Legal Compliance} op. cit. n.531, p.70
\textsuperscript{534} Welham, \textit{Corporate Manslaughter and Corporate Homicide: A Manager’s Guide to Legal Compliance} op. cit. n.531, p.95
'manslaughter' and 'homicide' in the title of the Act reflects the differing nature of Scottish law and the law of England and Wales and will be further explained in the next section of this Chapter.

5.3 Manslaughter, Culpable Homicide and Corporate Killing

The disasters discussed in the previous section illustrated some of the barriers encountered when applying the common law of manslaughter or culpable homicide to the act of corporate killing. The situation is complicated by the different legal systems in Scotland and England and Wales. In England and Wales, there is no offence of homicide, instead the term includes the common law offences of murder and manslaughter, along with a number of other offences created by statute such as causing death by dangerous driving. In England and Wales, the phrase ‘malice aforethought’ is the distinguishing feature of the offence of murder with mens rea being the intent to kill or cause grievous bodily harm. Although Herring expressed doubt about the validity of the term ‘malice aforethought’, he went on to describe different forms of malice that could result in a charge of murder, including general, express and implied malice. Intent to kill or to inflict grievous bodily harm are relatively straightforward interpretations of malice aforethought and Williams added a third set of circumstances where it may be present, “risk taking of certain (or uncertain) kind”. Herring suggested that the defendant would need to have realised that the resulting death was a “...virtual certainty...” of his or her actions, even if it was not the intention, for this third set of circumstances to be applicable.

The common law crime of murder in Scotland is very similar to that in England and Wales, including no distinct offence of homicide, which is a category

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536 Williams, *Textbook of Criminal Law* op. cit. n.347, p.245
537 Ibid
containing a group of offences including culpable homicide. Similar to England and Wales, the *mens rea* for murder in Scotland is the wicked intent to kill but previously, it had also included causing death through wicked or “...callous recklessness...”. MacDonald defined ‘wicked recklessness’ as “...a disposition depraved enough to be wholly regardless of consequences” and although this definition has been widely used in Scottish murder trials for many years it has recently been subject to qualification and criticism. In *HM Advocate v. Purcell* it was held that it was not enough to show ‘wicked recklessness’, there also had to be the intent to cause physical injury. Confirming this decision in *Samuel Petto v. HM Advocate*, the Lord Justice Clerk suggested that review of the mental element in murder was long overdue, being “...defined with the use of terms such as wicked, evil, felonious, depraved and so on, which may impede rather than conduce to analytical accuracy”.

Given the above, it is unlikely that *mens rea* for corporate murder could ever be established in respect of deaths arising from work activities, proving that a senior manager or managers showed intent to kill as a consequence of work activities would be extremely difficult if not impossible, but as discussed previously in this Chapter, attempts have been made use the law to punish organisations for the specific crime of causing death as a result of their activities. The common law crimes of manslaughter in England and Wales and culpable homicide in Scotland have both been used, with varying degrees of success, against organisations following deaths arising from their activities. Manslaughter has traditionally been defined as unlawful killing in the absence of malice aforethought. It is also been used as an alternative to the charge of murder which carries a mandatory life sentence, particularly in cases where the

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542 *HM Advocate v Purcell (Isaac Michael)* [2007] HCJ 13; 2008 JC 131 at para. 16
545 Williams, *Textbook of Criminal Law* op. cit. n.347, p.258

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partial defences of provocation, diminished responsibility or suicide pact have accepted.

Two types of manslaughter are generally recognised in England and Wales, voluntary and involuntary (although there is only one common law crime of manslaughter with no distinction between voluntary and involuntary). For the purposes of corporate killing, involuntary manslaughter which describes the crime of unintentional unlawful killing is the most relevant.\textsuperscript{546} There are variously considered to be two or three forms of involuntary manslaughter typically described as constructive, gross negligence or reckless, although some commentators cast doubt on whether or not the last is actually a separate form.\textsuperscript{547} The inconsistency over the forms of involuntary manslaughter is demonstrated by Williams’ previous categorisation of the crime as reckless manslaughter or constructive manslaughter.\textsuperscript{548}

Constructive manslaughter, also referred to as unlawful act manslaughter, describes the circumstances where the victim is killed in the course of an unlawful and dangerous act but where the accused is lacking the \textit{mens rea} of murder.\textsuperscript{549} It is interesting to consider why constructive manslaughter is not considered relevant in cases of death arising from work activities where the death can be directly attributed to an unlawful act (for example, a contravention of health and safety legislation). There would appear to be no prohibition in law on this form of manslaughter forming the basis for the prosecution of a corporation for causing deaths as consequence of their activities. The use of constructive manslaughter for deaths arising from work activities was discussed by Wells who, although holding the view that the idea of constructive manslaughter is in itself unappealing, was of the opinion that there was no reason why it could not be used and, indeed, could be easier to prove in cases of corporate killing.\textsuperscript{550} In 1994, the Law Commission argued that it would not be rational for unlawful act manslaughter to be used against corporations. This recommendation was based at least partly on the context of its

\textsuperscript{546} The Law Commission, \textit{Legislating the Criminal Code: Involuntary Manslaughter} (HMSO 1996) 12
\textsuperscript{547} Herring, \textit{Criminal Law} op. cit. n.538, p.150
\textsuperscript{548} Williams, \textit{Textbook of Criminal Law} op. cit. n.347, p.258
\textsuperscript{549} Herring, \textit{Criminal Law} op. cit. n.538, p.152
\textsuperscript{550} Wells, \textit{Corporations and Criminal Responsibility} op. cit. n.11, p.78
recommendation to abolish that particular offence but also to use it for the basis for serious criminal liability “would be likely to have effects which would be wholly random and erratic in their nature” but without giving any further explanation or justification for that view. The offence of constructive or unlawful manslaughter has not been abolished so one of the reasons given by the Law Commission for not considering it in the context of corporate killing, that is its abolition, did not happen. Although the Corporate Manslaughter and Corporate Homicide Act 2007 abolished the application of the common law offence of gross negligence manslaughter to corporations, it says nothing about constructive manslaughter.

The final category of manslaughter considered in this Chapter, the common law offences of gross negligence or reckless manslaughter in England and Wales, or culpable homicide in Scotland, was the most likely criminal prosecution for corporations held responsible for deaths arising from work activities. The Law Commission Report, Criminal Law: Involuntary Manslaughter muddies the waters a little by conflating the terms reckless and gross negligence, “...that of gross negligence or reckless manslaughter...” implying they are one and the same thing. Gross negligence manslaughter/culpable homicide and how they formed the basis of the corporate manslaughter and corporate homicide offences will be discussed in more detail in the next Section of this Chapter. There are further forms of murder, manslaughter and culpable homicide, including infanticide (in England and Wales), causing death whilst in charge of a motor vehicle and causing or allowing the death of a child or young adult. Each of these forms have little or no relevance to corporate killing so will not be discussed further in this thesis.

Whilst in theory, corporations could be guilty of the common law offences of gross negligence manslaughter or culpable homicide, the legal barriers for successful action against them, particularly the larger corporations were just too high. The identification doctrine made it all but impossible to prosecute large companies for manslaughter or culpable homicide and there was no prospect of

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551 The Law Commission, Law Commission Consultation Paper No 135, Involuntary Manslaughter (LCCP 135) op. cit. n.4, p.17
552 The Corporate Manslaughter and Corporate Homicide Act 2007 (c.19) S.20
553 The Law Commission, Law Commission Consultation Paper No 135, Involuntary Manslaughter (LCCP 135) op. cit. n.4, p.1
that changing unless there was change in the law which would recognise corporate killing as an offence in itself and for the identification doctrine to be confined to history. The following sections of this Chapter will discuss the tortuous path taken that finally resulted in the Corporate Manslaughter and Corporate Homicide Act 2007.

5.4 Reforming the Law

As illustrated in the previous section, the offence of manslaughter (and culpable homicide) has continued to evolve to reflect the changing nature of society, and the statutory response to corporate killing could be considered just one stage in its fragmentation. The concept of punishing employers directly for deaths arising from their activities has proved to be a contentious issue since the very earliest days of legislative control of safety in the workplace. As discussed in Chapter two, the Seventh Earl of Shaftsbury, Lord Ashley, in his Bill of 1833 proposed that if an operative was killed as the result of negligence in fencing dangerous parts of a machine, the mill-owner responsible was to be committed for trial on a charge of manslaughter. Needless to say, this particular proposal was not well received by the manufacturers of the day and was quickly expunged from the Bill but it is perhaps one of the first attempts to legislate for a specific class of manslaughter. It would be a further century and a half before the principle of holding employers directly accountable for deaths arising from their activities would gain widespread support.

The sequence of major accidents in the late nineteen-eighties discussed previously in this Chapter resulting in a significant loss of life demonstrated an apparent failure of the legal process to properly punish the corporations responsible for them. In some of those cases, large fines were imposed for contraventions of the Health and Safety at Work etc. Act 1974 but the regulatory nature of the 1974 Act and its relevant statutory provisions meant that corporations found guilty were not subject to the stigma that would be attached to the ‘real’ crime of manslaughter. Although by that time it had been

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554 Thomas, The Early Factory Legislation. A Study in Legislative and Administrative Evolution op. cit. n.60, p.44
established that a corporation could be found guilty of manslaughter, the ‘identification doctrine’ meant that any hope of a successful prosecution for the manslaughter offence could be expected only in respect of the very smallest organisations where the directing mind could be identified. In effect, large and medium-sized corporations could operate confident of their immunity from prosecution for manslaughter for deaths arising from their activities.

What could be considered the first major response by the establishment to the clamour for ‘something to be done’ took the form of the Law Commission consultation document, *Involuntary Manslaughter* (LC135), which was published in 1994. As the title suggests, the consultation extended beyond just corporate killing and considered the law relating to involuntary manslaughter more widely but, importantly, the Consultation Document did acknowledge that corporations could be guilty of manslaughter but it was emphatic that there should not be a separate law for corporate manslaughter, it should, instead, fall under the general law of manslaughter. The Consultation Document identified the difficulty in attaching “…conscious wrongdoing…” to corporations and their behaviour, or misbehaviour, but it went on to suggest that the crime of corporate manslaughter was not one of conscious wrong doing, but one of failure to do something. To address that particular difficulty, it suggested a different approach to corporate liability based on the question “…did the company’s operation fall seriously and significantly below what could reasonably be expected of it in the context of the significant risk of death or injury of which it should have been aware?” Although the Consultation Document’s recommendation that corporate manslaughter should not be separated from the law of general manslaughter did not survive, its approach to corporate liability did, at least in part.

Following the consultation period, in 1996, the Law Commission published its report *Legislating the Criminal Code: Involuntary Manslaughter*. The Report was based on the proposals contained in LC135 and comments received from a
range of individuals, organisations and other interested parties. The recommendations contained in the Report generally followed the proposals contained in the earlier consultation document and included the abolition of unlawful act killing and the creation of two offences to replace the single manslaughter offence, reckless killing and killing by gross carelessness. It recommended that the laws dealing with motor manslaughter should be left unchanged.

The Report recommended the creation of a new offence of corporate killing which would correspond with the individual offence of killing by gross negligence but unlike that offence, it would not be necessary for the risk to be obvious or for the defendant to be capable of appreciating that risk. The Report did recommend that it should not be possible for an individual to be charged with the offence of corporate killing. An interesting recommendation included in the Report was the possibility for the jury to convict the defendant of an offence under the Health and Safety at Work etc. Act 1974 where they were found not guilty of the offence of corporate killing. The Report also recommended that, on the application of the prosecution, the Health and Safety Executive or other appropriate body or person, an order could be made to require remedial action by the corporation to address the failures identified as the cause or causes of the deaths. The apparent close relationship between the Health and Safety at Work etc. Act 1974 and the proposed new offence of corporate killing was commented upon by Cahill and Cahill who observed that the implied need for safe systems of work reflected the requirement of the 1974 Act for risk assessment to be undertaken.\textsuperscript{560}

The report included a draft Involuntary Manslaughter Bill which laid down the new offences of reckless killing, killing by gross carelessness and corporate killing and included definitions of each offence and the penalties.\textsuperscript{561} Importantly, the proposed corporate killing offence focused on management failure of the corporation rather than the direct actions of an individual or group of individuals thus dispensing with the identification doctrine. A further point of note was the explicit inclusion of the potential prosecution of a corporation for

\textsuperscript{560} Cahill and Cahill, ‘Scarlet Letters: Punishing the Corporate Citizen’ op. cit. n.16, p.155
\textsuperscript{561} The Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* op. cit. n.546
both reckless killing and killing by gross carelessness. It was a relatively short Bill, running only to eleven sections but had it been adopted and implemented as it stood, it would have resulted in the most significant changes to the manslaughter offence in modern times with Wells describing them as “...daring and innovatory”, at least in respect of corporate killing. Wells went on to express some reservations about both the establishment of a separate corporate killing offence, on the ground that it might marginalise corporate killing even further, and the exclusion of directors and other senior managers from action for this offence. Making reference to other commentators, she suggested that enforcement action against companies was much more effective when taken against senior managers at the same time, although it is debatable that the corporate killing offence could be considered enforcement action in its truest sense.

Mays expressed some doubt that prosecutors would view “management failure” holistically in the context of an organisation’s activities which may have resulted in a death, instead he feared that prosecutors would look at the “...actions and conduct of senior actors in the corporate hierarchy...” when assessing management failure. To all intents and purposes, this is a reversion, at least in part, to the identification doctrine. This view was support to some extent by Wells, who commented upon the lack of a definition of “management” in the Law Commission’s Report, and expressed some doubt that the difficulty in proving “management failure” may still have resulted in a failed prosecution in the P&O case.

Whilst recognising the benefits of the proposed new “corporate killing” offence in facilitating successful prosecutions, Clarkson argued that it should be resisted for two reasons. Although the new offence may have made it easier to convict in the event of a death arising from an organisation’s activities, it would

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563 Ibid
565 Wells, ‘Corporate Killing’ op. cit. n.532, p.1468

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have no effect on any other offence committed by it. In respect of these offences, the identification doctrine would still apply, a point also made by Wells.\(^{567}\) Of major concern to Clarkson was the danger that the new offence would be considered something different from manslaughter and may lose some of the stigma and seriousness associated with it and lead to a further marginalisation in terms of enforcement. Perhaps one of the most critical commentators on the Law Commission Report was Trotter who identified a number of what she described as disadvantages including its restriction to deaths arising in the UK, the failure to include an individual offence applicable to senior executives, the failure to make senior executives personally liable for any penalties, inadequate level of fines and remedial orders that were too narrow in scope and application, the failure to have any systems to compensate victims’ families and the failure to require an improvement in corporate safety culture.\(^{568}\)

In the main, most of the criticism of the Law Commission report focussed on the failure to include an individual offence as well as the corporate killing offence, the vagueness and difficulty in establishing “managerial failure” and the danger that the new corporate killing offence may in some way reduce the stigma or seriousness that should be associated with causing death as a consequence of an organisation’s activities. How these criticisms were addressed by the Government’s proposals will be discussed below.

It would be a further four years before the Government published a formal response to the Law Commission Report in the form of *Reforming the Law on Involuntary Manslaughter: The Government’s Proposals*.\(^{569}\) In the forward to that document, the Home Secretary at the time, the Right Honourable Jack Straw MP, acknowledged the deficiencies of the law dealing with involuntary manslaughter in general, and corporate killing more specifically. Most of the Law Commission’s proposals were accepted although there were number of areas where a different view was taken. The Government accepted the proposal for two new offences to replace the existing manslaughter offence, reckless and

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\(^{567}\) Wells, ‘Corporate Killing’ op. cit. n.532, p.1468  
\(^{568}\) Stephanie Trotter, ‘Corporate Manslaughter’ (2000) 150 The New Law Journal 454  
\(^{569}\) The Home Office, *Reforming the Law on Involuntary Manslaughter: The Government’s Proposals* op. cit. n.8, p.4
gross carelessness killing but proposed a third offence to address concerns over
the proposed abolition of unlawful act manslaughter. The third offence would
cover those situations where a minor injury caused through an unlawful act
subsequently led to death which was unforeseeable. The Government argued
that a person who embarks upon illegal violence should be responsible for the
consequences although they might be unforeseeable.

By far the largest part of the Government’s proposals focussed on corporate
killing. Although the Law Commission’s proposal for the new offence of
corporate killing was accepted, there were a number changes and additions put
forward. To begin with, there was some concern over the restrictions imposed
through the use of the term ‘corporation’ in so far as some organisations might
fall outside its normal understanding and it was proposed that the application of
the offence to ‘undertakings’ rather than ‘corporations’ would be preferable.
The question of Crown immunity was raised but no proposal was made other
than to seek comments on the issue. On the question of investigation, the
Government proposed that in England and Wales, the Health and Safety
Executive, local authorities and other health and safety enforcing authorities
should be given the powers to investigate and prosecute the new offence, as
well as the Crown Prosecution Service and police.

The Law Commission explicitly excluded action being taken against individuals in
a company for corporate killing although they could still be prosecuted using the
more general new offences of reckless or gross carelessness killing. The
Government expressed some concern at this approach on the grounds that it
would not provide sufficient deterrence to large, wealthy companies and it
would not prevent ‘culpable individuals’ from establishing a new business
following the successful prosecution of their previous companies for the new
offence. To address that concern, it was proposed that an individual who could
be shown to have had some responsibility for the management failures leading to
the deaths and subsequent prosecution for the new offence should be
disqualified from subsequently acting in a management role in any undertaking.
Comments were sought on the questions of whether or not such individuals
should be subject to action in relation to the offence of corporate killing. As
stated previously, most of the other Law Commission proposals were accepted,
including the power to require remedial works, and responses were invited for submission by 1st September 2000. It should be noted that the Government’s proposals only extended to England and Wales with Scotland and Northern Ireland excluded as a consequence of their different legal systems. The Scottish response to the corporate killing question will be discussed later in this Chapter.

In 2003 following attempts by the Labour backbencher, Andrew Dinsmore, to table an amendment to the Criminal Justice Bill which was being debated at that time, the Home Secretary, David Blunkett made a statement confirming that the Government would publish a bill creating the offence of corporate manslaughter. In his statement, Blunkett stated that the criminal liability of company directors would not be included as part of the bill creating the new offence. It would be another two years before the draft bill was published, and then a further period of consultation before the Home Affairs and Work and Pensions Committees published their responses to the Government’s proposals. The offence contained in the draft bill focussed on gross management failure based on conduct that would fall far below what could be reasonably expected. Importantly, the application of the Act to individuals was excluded even though the Government itself expressed concern that the failure to extend the offence to include individuals could diminish its effectiveness. Individuals could still be subject to prosecution for the common law offence of manslaughter, offences under the health and safety legislation and disqualification as a director under the then existing legislation.

Much of the debate that resulted as a consequence of the publication of the Government’s proposals reflected that which followed the Law Commission’s Report and focussed on the lack of an individual offence and the difficulty in establishing “management failure”. Berry questioned whether the draft Bill really brought anything new to the table, mainly on the grounds that it did not

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572 Home Affairs and Work and Pensions Committees, Draft Corporate Manslaughter Bill. HC540-I (HMSO 2005)
include an individual offence for company directors. Clarkson also commented upon the failure to include an individual offence but he also expressed disappointment that the Bill was limited to deaths arising from an organisation’s activities, and he suggested that it should have included the offence of causing serious personal injury. He also commented on the change of name of the offence from “corporate killing” to “corporate manslaughter”, without any explanation. He considered the original offence of corporate killing a more appropriate description of the wrongdoing, although as discussed previously in this section, that view is not necessarily shared by other commentators.

Almond commented upon the allocation of investigation of possible corporate manslaughter cases to the police, rather than the Health and Safety Executive. This contradicted the Government’s original response to the Law Commission Report which was to allocate enforcement of the new offence to the Health and Safety Executive. Almond associated this change to the decriminalisation of health and safety law in the preceding years.

The role of “senior management” in establishing the offence of corporate manslaughter was discussed at length by Griffin who expressed concern not just in the determination of who “senior management” would be, but also the need to show their activities were a substantial component of the gross breach of a relevant duty of care. The need to demonstrate gross negligence by the organisation also caused Griffin some concern and he considered, apart from the vagueness of the term, the size, type of industry and wealth of the company will all conspire to produce variable outcomes. Concluding, Griffin did not consider the Bill to be a radical departure on the common law it would replace, there would be few additional prosecutions and it was regretful that individual board

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573 Christopher Berry, ‘Corporate Manslaughter’ (2006) 46 Medicine, Science and the Law 2 6

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members would be able “...to hide behind the corporate veil, free from any personal responsibility...”.

The Bill applied only to England and Wales and between the publication of the draft Bill in March 2005 and the Committee’s Report mentioned in the previous paragraph, the Corporate Homicide Expert Group set up by the Scottish Executive published its report on Corporate Homicide. In many respects, it was similar to the Government Bill for England and Wales, in particular the focus on ‘management failure’, although some of the differences between the two documents were quite significant. The Expert Group considered ‘recklessness’ to be an important component of the new offence of corporate homicide whereas in England and Wales, the term ‘gross breach’ was adopted. The Expert Group also felt there was little benefit in adopting the concept of ‘duty of care’ which was an important part of the England and Wales Bill. Perhaps one of the most significant differences was the approach by the Expert Group to individual liability. Its Report recommended both an individual offence and a secondary offence where the individual offence could apply to any person in the organisation responsible for causing the death as a consequence of their work activities. This offence would not require the organisation to also be guilty of corporate homicide. The secondary offence would apply to individual directors or senior managers and would apply where the organisation had been found guilty of corporate homicide and it was held that the acts or omissions of an individual at a senior level directly contributed to the death. As the Expert Group pointed out, this reflected the Health and Safety at Work etc. Act 1974 where an individual offence existed in terms of Section 7 of that Act and a secondary offence in terms of Section 37. The Expert Group did accept that it would be desirable for the UK legal jurisdictions to be aligned in dealing with corporate manslaughter/corporate homicide, but it was critical of the draft Bill published for England and Wales and considered it unsuitable for application in Scotland.

Chalmers was rather critical of the report of the Expert Group, suggesting that one of its main shortcomings was the failure to rule any options out which meant

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577 Ibid
578 The Scottish Executive, Corporate Homicide: Expert Group Report, 2005
579 Ibid
that there were no clear recommendations for the Scottish Executive to accept or reject.\textsuperscript{580} Chalmers also expressed concern about the dismissal by the Expert Group of the view that making individual senior managers and directors liable for the offence could be a disincentive for executives to accept these posts in Scotland although he did accept that some of his reservations could be allayed if the individual liability was more clearly explained. Other concerns expressed by Chalmers included the failure of the Group to examine in depth the relationship between the proposed offence and the existing health and safety statutory provisions, going as far as to suggest that if there was no offence in terms of health and safety legislation, there could be no proceedings for the new offence and conversely, if there was a breach of health and safety legislation then there would be no need to demonstrate management failure in terms of the new offence. In this suggestion, Chalmers viewed the new offence as an extension, in some ways, to the health and safety legislation and whilst it could be assumed that most corporate homicide offences would be related to health and safety offences, there could be circumstances where the deaths arose from other forms of management failure. Chalmers’ last area of concern was in sentencing where he felt that there was just too wide a range of options available to the courts and that expertise in sentencing corporate homicide offences would not be developed.

The Home Affairs and Work and Pensions Committee Report \textit{Draft Corporate Manslaughter Bill} was published on 12\textsuperscript{th} December 2005 and although it welcomed the Government’s proposals to introduce the new offence of corporate manslaughter (rather than corporate killing), it did express a number of concerns and made recommendations.\textsuperscript{581} The Government’s response to the Home Affairs and Work and Pensions Committee Report was published in March 2006 and the revised Bill eventually receiving Royal Assent on 27\textsuperscript{th} July 2007 as the \textit{Corporate Manslaughter and Corporate Homicide Act 2007}.\textsuperscript{582} It is interesting to note that even at that late stage, the Government’s draft Bill still


\textsuperscript{581} Home Affairs and Work and Pensions Committees, \textit{Draft Corporate Manslaughter Bill}. HC540-I op. cit. n.572, p.94

extended to only England and Wales, although the Home Affairs and Work and Pensions Committee suggested that the recommendations contained in its report would bring the draft Bill close to the reforms proposed in Scotland.

In June 2006, Karen Gillon, MSP, published a consultation paper containing a draft Culpable Homicide Bill for Scotland which, amongst other things, introduced the new offence of corporate culpable homicide by causing death recklessly. Gillon’s consultation document also included a secondary offence where office holders in an organisation could also be guilty of the offence if they were held responsible for the activities that caused the death, something that was not included in the UK Government’s Bill. At some point in time after the publication of Gillon’s consultation document, it was decided that corporate manslaughter/corporate homicide was too closely linked to health and safety issues which was a reserved matter for Westminster and as such, the Westminster Act would apply to the whole of the UK. Some commentators in Scotland were far from impressed by this turn of events and Bob Thompson, writing in the Scottish Left Review argued that “Out of the blue, Whitehall stated that Health and Safety was a reserved matter for Westminster and the Scottish Bill was not competent. The Scottish Executive cravenly agreed without any discussion, and the Bill was dropped”.

The outcome of thirteen years formal consultation was the Corporate Manslaughter and Corporate Homicide Act 2007 (the “Act”) which was given Royal Assent on the 26th July 2007 and applied to the whole of the United Kingdom. The Act came into force on 6th April 2008 with the intention of clarifying the law in respect to fatal accidents arising from an organisation’s activities. Paul Goggins, the Criminal Justice Minister at the time of the Act’s commencement, stated that “This important UK-wide legislation is a major step

584 Ministry of Justice, A guide to the Corporate Manslaughter and Corporate Homicide Act op. cit. n.18
586 The Corporate Manslaughter and Corporate Homicide Act 2007 (c.19)
forward for protecting consumers and workers from grossly negligent corporations”.

Although Goggins clearly focused on consumer and worker safety, the Act is not ‘health and safety legislation’ in the normal meaning of the term, nor is it enforced by the health and safety enforcing agencies in the UK although there is clearly a close link between it and the existing health and safety legislation, as demonstrated by the decision to remove corporate homicide from the Scottish Parliament’s ambit, as discussed in preceding paragraphs. Instead, investigations were to be led by the police and any proceedings for corporate manslaughter would be the responsibility of the Crown Prosecution Service in England and Wales, the Procurator Fiscal in Scotland and the Public Prosecution Service in Northern Ireland.

It was expected that the expertise of the Health and Safety Executive and other enforcing agencies would be “properly harnessed” in the event of any investigation that could lead to charges in terms of the Act.

5.5 The Act

The Act, which came into force on 6th April, 2008, applies to the whole of the UK and introduces two new offences, corporate manslaughter (England, Wales and Northern Ireland) and corporate homicide (Scotland). Many of the comments and recommendations made and received throughout the extended consultation period informed the final contents and wording of the Act but equally, some of the concerns expressed, particularly by the Scottish Executive Expert Group, were not included in the Act. In some respects, there seems to have been a bit of a rush to introduce the Act in the last few months of its gestation, given the previous 13 years of what could best be described as a relatively leisurely pace of development.


588 Ministry of Justice, A guide to the Corporate Manslaughter and Corporate Homicide Act op. cit. n.18
The Act applies to most companies, corporations, partnerships, trades unions, police forces and government departments. Schedule 1 of the Act lists the departments that it applies to and Section 21 allows the Secretary of State to extend the categories of organisations subject to the requirements of the Act. There are some types of organisations that fall outside its scope but most will be included. It is worth noting that the Act applies to Crown Bodies, the Armed Forces and the Police although there are exemptions for military activities, policing operations in respect of civil disorder, terrorism or serious disorder, and other emergencies. This will be discussed in more detail later in this section.

Section 1 of the 2007 Act makes it an offence for an organisation to cause the death of a person as a consequence of its “...gross breach of a relevant duty of care...” owed to the victim. The term ‘organisation’ includes a corporation, department or other body as listed in Schedule 1 (discussed in the previous paragraph), a police force, partnership, trade union or employers’ association where they are an employer. It is important to note that a prosecution for corporate manslaughter or corporate homicide can only be taken against a company; individuals within the company cannot be guilty of this offence irrespective of their role leading to the death but they can be prosecuted for gross negligence manslaughter.

For an offence to be committed in terms of the Act, the organisation must have owed a relevant duty of care to the victim, a “gross” breach of that duty of care resulting in the victim’s death must be demonstrated with a substantial part of the gross breach of duty attributed to “...the way in which its activities are managed or organised by its senior management”. A relevant duty of care is one owed in the law of negligence and would not include the statutory duties imposed by health and safety legislation although there would clearly be significant overlap between the two types of duties. The used of ‘duty of care’ was specifically considered by the Scottish Executive Expert Group which concluded that there were “...no particular advantages...” to the importation of the concept and it had concerns about “...adopting wholly civil concepts into criminal law...”.\textsuperscript{589} The implementation of what could be considered a foreign concept into the Scottish legal system, at least so far as criminal law is

\textsuperscript{589} The Scottish Executive, Corporate Homicide: Expert Group Report op. cit. n.578, p.9
concerned was addressed in the Ministry of Justice guide in a single sentence, “...the concepts of negligence and duty of care are familiar from the civil law”, effectively ignoring the concerns expressed by the Expert Group although the subsequent definition of duty of care shown below does include circumstances familiar to Scottish Law.  

Section 2 (1) of the Act explicitly defines an organisation’s duty of care as “...any of the following duties owed by it under the laws of negligence” and includes a duty owed to employees or other persons working for it, a duty owed as occupier of premises, a duty owed in the connection with the supply of goods or services, the carrying on of any construction or maintenance operations, the carrying on of any other activity on a commercial basis or the use or keeping of any plant, vehicle or other thing, and finally, a duty owed to a person for whose safety the organisation is responsible in terms of subsection 2 of the Act.

Although only a duty of care owed in the law of negligence will be a ‘relevant duty of care’, there is considerable overlap with those found in health and safety legislation, in particular sections 2, 3 and 4 of the Health and Safety at Work etc. Act 1974. The duty of care contained in the 2007 Act is more extensive than the statutory duties contained in the 1974 Act and could include products and environmental liabilities. Pointing out that the ‘duty of care’ requirement was not included in the 1996 or 2000 consultation papers and its inclusion was advised against by the Home Affairs and Work and Pensions Committee in 2005, Gobert suggested that it is “…otiose...” and would only provide defendants with an opportunity to deflect attention from the organisations role in causing the death which led to the prosecution.

Whether or not an organisation owes a duty of care will be a question of law and the judge must make “any findings of fact necessary to decide that question” (S.2(5)). In effect, it is for the judge to decide whether or not the duty of care was owed by the organisation to an individual. This would appear to contradict the common law position where the jury would decide if a duty of care exists.

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590 Ministry of Justice, *A guide to the Corporate Manslaughter and Corporate Homicide Act* op. cit. n.18, p.9
591 Stuart Armstrong, ‘On Your Head Be It’ (2008) 142 Accountancy 100 101
592 James Gobert, ‘The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?’ (2008) 71 Modern Law Review 413 416
but Whelan suggested that the complexities of determining whether or not the victim was an employee of the organisation could prove too challenging.\textsuperscript{593} Hopwood, Edum-Fotwe and Adams suggested that S.2(5) will clarify whether or not a duty of care is owed making appeals on these grounds much less likely.\textsuperscript{594}

A useful reference point to establish whether a duty of care is owed can be found in \textit{Caparo Industries plc v. Dickman}. This case led to the creation of the “three-fold test”; harm must be a “reasonably foreseeable” consequence of the defendant’s actions; a relationship of “proximity” between the defendant and the claimant must exist; it must be “fair, reasonable and just” to impose liability on the defendant.\textsuperscript{595} The term ‘proximity’ is difficult to define and means more than physical closeness. It can be considered the extent of the relationship between the defendant and the plaintiff and it has been described as a relationship equivalent to contract or only falling just short of a direct contractual relationship. It has also been related to the assumption of responsibility by the defendant prior to the loss. In \textit{Sutradhar (FC) v Natural Environment Research Council}, Lord Hoffman described proximity as “...the sense of a measure of control over and responsibility for the potentially dangerous situation.”\textsuperscript{596} In the same case, Lord Mance commented on the “...the imprecision of the concept and the many criticisms it has attracted down the years...” and it is likely to continue to present challenges in the interpretation of duty of care in respect of corporate manslaughter and corporate homicide cases.

A ‘gross breach’ of a relevant duty of care will occur where the breach of that duty “...falls far below what can reasonably be expected of the organisation in the circumstances”. With terms like “far below” and “can reasonably be expected”, establishing gross breach may not be an easy task and it will fall to the jury to decide whether or not such a breach has taken place. The threshold of the offence is gross negligence\textsuperscript{597} which was discussed in the case of \textit{R v}

\begin{itemize}
\item \textsuperscript{593} Ormerod and Taylor, ‘The Corporate Manslaughter and Corporate Homicide Act 2007’ \textit{op. cit.} n.3, p.601, Welham, \textit{Corporate Manslaughter and Corporate Homicide: A Manager’s Guide to Legal Compliance} \textit{op. cit.} n.531, p.151
\item \textsuperscript{594} Hopwood, Edum-Fotwe and Adams, ‘The Impact of the Corporate Manslaughter and Corporate Homicide Act 2007 on the Construction Industry in the UK’ \textit{op. cit.} n.500
\item \textsuperscript{595} \textit{Caparo Industries plc v. Dickman} [1990] 2 AC 605 (HL)
\item \textsuperscript{596} \textit{Sutradhar (FC) v Natural Environment Research Council} [2006] UKHL 33, on appeal from [2004] EWCA Civ 175 2006 WL 1783209 (HL) Para. 38
\item \textsuperscript{597} Ministry of Justice, \textit{A guide to the Corporate Manslaughter and Corporate Homicide Act} \textit{op. cit.} n.18, p.12
\end{itemize}
Adomako where, making reference to Andrews v DPP, Lord Mackay proposed that in the case of manslaughter, four facts must be established:- there is a duty of care owed by the defendant to the victim; the duty of care was breached; the breach of duty caused the victim’s death; the breach of duty can be characterised as gross negligence. 598 It is interesting to note that the recommendations of the Scottish Executive Expert Group which proposed “recklessness” as the key component for the corporate homicide offence were not included in the 2007 Act.599

Determining whether or not the breach of duty amounted to gross negligence will require the jury to decide whether or not the defendant’s conduct departed to such an extent from what could reasonably be expected that it should be considered criminal. In R v Adomako Lord Mackay commented on the circularity of this approach but was satisfied that it was a correct test of how far conduct must depart from what would be considered acceptable to what would be judged criminal. Whether it is, as Mackay suggests, the correct approach or not, determining if a gross breach of a duty of care has occurred will not be an easy task for any jury. Almond points out that “…the requirement that the management of corporate activities should amount to a gross breach of a duty of care allows for uncertainty to exist over exactly how bad a breach must be to be gross…”600 although Section 8 of the Act provides a number of factors for the jury to consider when determining whether or not the actions of the organisation amount to a gross breach of their duty of care to the victim.

Section 8 of the Act requires the jury, when determining if there has been a gross breach of duty, to consider whether the organisation failed to comply with any health and safety legislation relating to the breach of duty and if so, how serious that failure was, and how much of a risk of death it posed. Griffin suggested that determining how serious the failure was and how much of a risk to death it posed “…will require the jury to navigate a number of problematical questions of interpretation…”.601 When considering the extent of the organisation’s failure, the jury can have regard to any health and safety

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599 The Scottish Executive, Corporate Homicide: Expert Group Report op. cit. n.578, p.9
600 Almond, Corporate Manslaughter and Regulatory Reform op. cit. n.503, p.173
601 Griffin, ‘Corporate Manslaughter: A Radical Reform?’ op. cit. n.576, p.161
guidance relevant to the alleged breach of duty including Approved Codes of Practice, industry standards, and any other guidance thought appropriate in the circumstances. The jury can also have regard to any other matters they think relevant. As discussed previously, the Act is not health and safety legislation and its application is wider than deaths arising from work activities, whether to employees or anyone else, but section 8 specifically refers to the failure of an organisation to comply with health and safety legislation. Whilst this may assist the jury in cases where the death has arisen from workplace accidents, it may be of little benefit in non-work related deaths and there is a danger that the 2007 Act will be seen as an extension of health and safety legislation.

The jury can also take into account how far the attitudes, policies, systems or accepted practices contributed to or encouraged the failure or developed a tolerance to it. This introduces the concept of organisational or corporate culture and the phrase “...including cultural issues within the organisation...” is used in the explanatory notes.602 Before an organisation can be found guilty of the offence of corporate manslaughter, it must be shown that the death or deaths arose due to the way the senior management managed or organised its activities (S1(3)), that is, it must be shown that the culture of the organisation was in the main responsible for the fatality. The concept of culture is now well established in the field of health and safety and is typically defined as an organisation’s “...appropriate behaviour, bonds and motivates individuals and asserts solutions where there is ambiguity”.603 Wells suggests that corporate culture can be “...found in an attitude, policy, rule, course of conduct or practice within the corporate body...”.604 The culture of organisations has frequently been identified as the root cause of many of the accidents discussed previously in this Chapter, including Piper Alpha, the Herald of Free Enterprise and the Clapham Train Crash but obtaining information on a corporation’s culture at any point in time, or the culture of a division or group within a large organisation, could prove difficult.605

603 Charles Hampden-Turner, Corporate Culture. From Vicious to Virtuous Circles (1990) 18
605 Allens Arthur Robinson, ‘Corporate Culture as a Basis for the Criminal Liability of Corporations’ op. cit. n.498, p.17
For an organisation to be guilty of an offence, the way its “senior management” manages or organises its activities must be a substantial element of the circumstances leading to the victim’s death. 606 “Senior management” is defined as persons who play a significant role in making decisions about how the whole or a substantial part of the organisations activities are managed or organised, or the actual managing or organising of the whole or substantial part of the organisations activities, in effect, the corporate culture of the organisation. Almond expressed some concern about this focus on senior management, suggesting that it could cause the identification principle to endure since it would be necessary to identify the senior manager(s) responsible the organisation or management of its activities in order to demonstrate that the actions of senior management were a significant element of the offence. 607 Almond’s view is supported by Clough who goes on to suggest that larger organisations may delegate the health and safety responsibility to “…non-senior level managers…” although this is more difficult than it may appear for the reasons discussed below. 608 Clough also suggests activities that may fall under the responsibility of senior management in a small organisation may be at a much lower level in a large organisation resulting in the Act having a disproportionate effect on them.

The Explanatory Notes to the Act state that management failure “need not have been the sole cause of death; it need only be a cause…” 609 but this is qualified by the need to show it was a “substantial element” in the circumstances giving rise to the offence. This makes the liability of the organisation conditional rather than absolute and allows employers the defence of “the break of chain of causation” where an employee may have been the immediate cause of the accident through their own actions contrary to the organisation’s instructions. 610 If it could be reasonably expected that employees may ignore or contravene any such instructions, or there was inadequate supervision, this could indicate a poor

606 The Corporate Manslaughter and Corporate Homicide Act 2007 (c.19) S.1(3)
607 Almond, ‘Regulation Crisis: Evaluating the Potential Legitimizing Effects of “Corporate Manslaughter” Cases’ op. cit. n.575
609 Ministry of Justice, Corporate Manslaughter and Corporate Homicide Act 2007. Explanatory Notes. op. cit. n.602, p.3
610 The Law Commission, Legislating the Criminal Code: Involuntary Manslaughter op. cit. n.546, p.111
safety culture and the organisation could still be found guilty of the offence of corporate manslaughter/corporate homicide. In the case of English v Wilsons & Clyde Coal Co Ltd, Lord Wright concluded that employers had a duty "...which is personal to the employer, to take reasonable care for the safety of his workmen, whether the employer be an individual, a firm or a company and whether or not the employer takes any share in the conduct of the operations..." which has been construed as meaning that health and safety duties cannot be delegated.\(^{611}\) It is not enough for an organisation to put a safe system of work or other safety measures in place, they must ensure that they are properly implemented. The consequences of requiring the offence to have a substantial element attributed to the way senior management organises or manages its activities will only be known when cases similar to Piper Alpha, the Herald of Free Enterprise or the Larkhall gas explosion (and others) occur at some point in the future. In all of these cases (and many others), management failures were identified as substantial elements of the circumstances leading to the accidents.

Section 2(1(d)) of the Act deals specifically with people who could be considered in the care of the State at the time of death and Section 2(2) goes on to list the categories that this part of the Act applies to include: persons detained in prison or similar institution, a police station or a custody area in a court; persons detained at a removal centre or holding facility; a person being transported or held for transport as part of a prison or immigration escort arrangement; a person living in secure accommodation; a detained patient. The application of the Act to these categories led Gobert to suggest that prisons could be prosecuted for deaths in custody arising from inadequate staffing levels caused by budgetary constraints imposed by government.\(^{612}\) Ormerod and Taylor took a different view and stated “If the death is attributable to a resourcing issue the duty of care will be one relating to a decision on a matter of public policy and therefore be totally excluded by s.3(1)”.\(^{613}\) This section has not been tested at the time of writing and when, or if, it is, it will almost certainly be contentious since resourcing issues may or may not be a matter of public policy and only

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\(^{611}\) English v Wilsons & Clyde Coal Co Ltd [1938] AC 57, [1937] UKHL 2, [1937] 3 All ER 628 (HL) 17

\(^{612}\) Gobert, 'The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?' op. cit. n.592, p.415

\(^{613}\) Ormerod and Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' op. cit. n.3, p.602
when it is, will the public authority be excluded as a consequence of S.3(1). This section states that any duty owed by a public authority which is subject to public policy (the Act specifically makes mention of the allocation of public resources) will not be a relevant duty of care. While the debate about whether or not public authorities should be exempt from the Act will continue, this will make their prosecution for corporate manslaughter more difficult than would otherwise be the case, particularly in times of budgetary cutbacks imposed by central government. There will, however, be a difference between resource allocation as a consequence of public policy and resource allocation as a consequence of local budgetary decisions.

Section 3 goes on to exclude any duty of care owed in respect the carrying out an “exclusively public function” or inspections in the exercise of a statutory function. The exclusion of these two categories is qualified and where the duty of care falls under S.2(1)(a), (b) or (d), i.e., owed to employees and other persons working for it, or owed as the occupier of premises or to persons in the care of an organisation, it will still be “a relevant duty of care”. This means that only the duty owed in terms of S.2(1)(c) will be subject to the “exclusively public function” exclusion. The exclusion on the basis of “exclusively public function” was commented upon in the Home Affairs and Work and Pensions Committee Report with some witnesses to its inquiry suggesting that it introduced Crown Immunity by the back door.614 Perhaps of more concern was the lack of clarity in what was meant by “exclusively public function” with the Committee identifying both a narrow and broad interpretation of what it would include. The Committee recommended that this exclusion should be removed and if it was to be retained, a much clearer definition of what it included should be provided. Neither of these recommendations was accepted by the Government and the “exclusively public function” exclusion and its interpretation remained unchanged in the Act. The Explanatory Notes to the Act discuss the concept of “exclusively public function” but other than to give the

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614 Home Affairs and Work and Pensions Committees, Draft Corporate Manslaughter Bill. HC540-I op. cit. n.572, p.54
example of the Government providing services in the event of civil emergency, it
does not clarify what the exclusion would or would not include.615

Sections 3 to 7 of the Act deal with branches of government at both local and
national levels and in effect exempts some or all of the activities carried on by
them from prosecution under the Act. Section 3 has already been discussed and
deals primarily with the relationship between public policy decisions, exclusive
public functions and statutory inspections and the “relevant duty of care”. The
other significant exemptions include certain types of military activities such as
peacekeeping operations, anti-terrorism actions, civil unrest and serious public
disorder where members of the armed services come under attack or the threat
of attack or violence. Hazardous training is also excluded from “relevant duty of
care”. Outside these exclusions, the Ministry of Defence may still be prosecuted
in terms of the Act for corporate manslaughter or corporate homicide where it
can be shown that it has failed in its duty as an employer or occupier. An
interesting exception to this is any duty of care owed by the Ministry of Defence
to any member of the special forces is not a “relevant duty of care”, as Ormerod
and Taylor observed, so far as special forces are concerned “everything is off
limits”.616

Described by Ormerod and Taylor as “complex”, there are similar exemptions,
for the police contained in Section 5 of the Act.617 Section 5(1) and (2) make
any duty of care arising from certain types of operations described below,
including their preparation and support, not a “relevant duty of care” and are
absolutely excluded under these specific circumstances. These operations
include counter-terrorism, civil unrest or serious disorder. This would suggest
that the police would not be subject to corporate manslaughter or corporate
homicide charges should a case similar to that of Jean Charles de Menezes recur
in the future, although individual officers could still face manslaughter charges.
De Menezes was shot to death by firearms officers of the Metropolitan Police
who wrongly suspected him of being a terrorist and subsequent investigations by

615 Ministry of Justice, Corporate Manslaughter and Corporate Homicide Act 2007. Explanatory
Notes. op. cit. n.602, p.7
n.3, p.608
617 Ibid
the Independent Police Complaints Commission identified a catalogue of errors at almost every level of the Police operation and made recommendations to the Crown Prosecution Service (CPS). The Independent Police Complaints Commission, *Stockwell One. Investigation into the shooting of Jean Charles de Menezes at Stockwell underground station on 22 July 2005.*, 2007. In a subsequent press release, a CPS senior lawyer, Stephen O’Doherty confirmed that although charges of murder, manslaughter, forgery and health and safety offences were considered, only the health and safety offences would be pursued. The Metropolitan Police was subsequently found guilty for offences in terms of the Health and Safety at Work etc. Act 1974 in respect of the killing of de Menezes and fined £175,000 with £385,000 in costs awarded against it. Should a police officer die whilst on an anti-terrorist operation as a direct consequence of inadequate training, instruction or protective equipment, the only possible prosecution that could be brought against the employing police force would be in terms of the health and safety legislation, unless an individual(s) was prosecuted for gross negligence manslaughter.

Section 5(3) of the Act introduces a narrower exclusion but for a wider range of general police or law enforcement activities in so far as any duty of care is not a “relevant duty of care” unless it falls under Section 2(1)(a), (b) or (d), that is, those subsections dealing with the duty to employees and members of the public, duty as occupier and duty to persons under its care. This means that any death arising as a consequence of the pursuit of law enforcement activities will be excluded from the offence of corporate manslaughter or corporate homicide, as made clear in the Explanatory Notes to the Act. The Explanatory Notes give examples where this exclusion will apply including “...decisions about and responses to emergency calls, the manner in which particular police operations are conducted, the way in which law enforcement and other coercive powers are exercised, measures taken to protect witnesses and the arrest and detention of suspects”. This section extends beyond just police forces and applies to other public authorities with statutory functions such as the Immigration and Border Agency, Customs and Excise, and so on. As with the

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armed forces, police forces could still be prosecuted under the Act in respect of their duties as employer or occupier so long as these duties do not fall under the exemptions stated above and individuals could be prosecuted for gross negligence manslaughter.

Section 6 of the Act exempts the emergency services from the offence of corporate manslaughter only in respect in the way in which they respond to emergency situations. This exemption is much more limited than for either the police or armed services and focuses on the speed of response to emergencies and how they are subsequently dealt with. The Act will still apply in respect of medical treatment but not the order in which persons are given treatment, i.e., triage carried out at the site of the emergency would still be exempt from the Act. Failures in vehicle maintenance, training, etc., directly resulting in death even if it did occur during an emergency response could still result in a charge of corporate manslaughter being laid against the emergency service.

Horder expressed a number of reservations over the exemptions afforded in general, but seems to be particularly concerned in respect of those for the military and the police. He suggested that exempting these organisations from prosecution for corporate manslaughter may make it more likely that individual police officers and service men and women will be prosecuted for gross negligence manslaughter since there will be no alternatives for prosecutors. Holder also suggested that these exemptions could encourage the police and, more likely, the military to ignore all health and safety considerations when planning certain types of operations. He went on to say that “...There is a case for saying that the exemption is undesirable and unnecessary” at least partly on the grounds that any prosecution would require the consent of the Director of Public Prosecutions or the Procurator Fiscal which would result in the public interest test being applied.

The final major exemption from the Act is child protection and probation functions, and are not particularly contentious. Section 7 extends partial exemption from the Act in respect of the duty of care owed by a relevant

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authority in terms of Parts 4 and 5 of the Children Act 1989, and its equivalent in Scotland and Northern Ireland. A similar exemption is extended to the probations services in terms of the duty of care owed in terms of The Criminal Justice and Court Services Act 2000. The exemption from the Act described in Section 7 does not include the duty of care owed as employers, occupiers of premises and relating to detention (in the case of probation boards). These will still fall under the category “relevant duty of care” and as such, a breach of them resulting in a death could still be prosecuted in terms of the Act.

The penalties for offences will be discussed in detail in the next section but the final few sections of the 2007 Act are mainly administrative in nature and have been touched upon elsewhere in this Chapter. Sections 11 to 14 expand upon the application of the Act to specific categories of organisations, including Crown bodies, the armed forces and police forces. The exemptions previously discussed notwithstanding, the Act will generally apply to these organisations. Section 14 extends the Act to partnerships, which are to be treated as bodies corporate.

One significant departure from the Health and Safety at Work etc. Act 1974 is the process for proceedings for an offence in England and Wales. The Director of Public Prosecution’s consent must be obtained (in Northern Ireland, the Director of Public Prosecutions for Northern Ireland) prior to proceedings being initiated. It is very unlikely that this will have a significant effect; given the serious nature of the circumstances that could lead to a possible prosecution in terms of the 2007 Act, it is unlikely that an Inspector in England and Wales would prosecute in the magistrates’ court as allowed by the 1974 Act in similar circumstances. 622 In Scotland, the Lord Advocate instigates all proceedings on indictment negating the need for a consent mechanism which would normally ensure that there is a reasonable chance of a successful prosecution and that it is in the public interest to pursue one.

The Act prohibits any individual liability for the offence of corporate manslaughter or corporate homicide although the charge of gross negligence manslaughter can still be brought against individuals held responsible for the

622 The Health and Safety at Work etc. Act 1974 (c.37), Section 39
deaths of others. The individual offences included in health and safety legislation as discussed in Sections 3 and 5 of this paper will also still apply. Prosecutions can be taken under both the 2007 Act and relevant health and safety legislation in respect of the same set of circumstances.

Finally, the Act abolishes the common law offence of manslaughter by gross negligence in its application to corporations and other organisations to which the new offence applies.

5.6 Penalties

All criminal enactments in a sense serve the double purpose of singling out wrongdoers for the purpose of punishment or correction and of regulating the social order.623

The penalties available for corporate wrongdoing cannot be exactly the same as those for individuals found guilty of unlawful activity, for example, a corporation cannot be imprisoned. The impact of even a large fine on a corporation will be different from a small fine imposed upon an individual who is personally responsible for paying it, whereas any fine imposed upon a corporation will ultimately be paid by clients, customers or shareholders. If the 2007 Act is to have any impact upon organisations, penalties that have real implications for offending corporations must be available to the courts. Before the nature of punishment can be discussed, it is necessary to consider whether a corporation can actually be punished, rather than it deserving of punishment. The effective punishment of corporate crime has been identified as serious problem by many commentators; before going on to suggest a number of approaches to address the perceived difficulties of punishing corporations, Coffee restated the general view that “...the problem of corporate punishment seems perversely insoluble: moderate fines do not deter, while severe penalties flow through the corporate shell and fall on the relatively blameless”.624 Various penalties can be imposed upon corporate law breakers but whether or not a non-sentient entity in the

623 Francis Bowes Sayre, 'Public Welfare Offenses' (1933) 33 Columbia Law Review 55
624 Coffee Jr, "No Soul to Damn: No Body to Kick": An Unscandalized Inquiry into the Problem of Corporate Punishment” op. cit. n.384, p.386
form of a corporation can be effectively ‘punished’ will always be questioned, no matter how severe the penalty.

Before addressing how a corporation can be *effectively* punished, the purpose of punishment must be considered and this will normally include one or more of retribution, deterrence, incapacitation or rehabilitation. Retribution or deterrence can be considered the more traditional goal(s) (although incapacitation and rehabilitation may have a role to play even in the case of corporate crime) and while there have been centuries’ worth of debate on which is most appropriate, effective or even fairest, an element of both will inevitably be a consequence of any penalty imposed upon conviction, particularly when it comes to corporate crime. At their most basic, deterrence is intended to prevent crime occurring in the future while retribution is a form of retaliation for crimes already committed. Reflecting on some of the major accidents discussed previously, such as the Herald of Free Enterprise, the Southall and Hatfield train crashes and the Larkhall gas explosion, it must be assumed that there would be a desire for punishment as just deserts (and possibly even revenge) as well as acting as a deterrence for organisations behaving in a similar way in the future. When discussing the minimum term for murder, the Law Commission points out that it must be long enough to satisfy the demands of both retribution and deterrence thus illustrating the importance of satisfying both possible goals of punishment.

Gerber and Jackson defined retribution as “...the support of punishment to restore justice and balance in society, or as a preference for retaliation and an expression of vindictiveness.” They went on to define two separate categories of retribution; as a mechanism for revenge or for “...restoring a sense of justice through proportional compensation from the offender...”, commonly referred to as just deserts, although there is a rather fine distinction to be drawn between revenge and just deserts. The debate about the role of retribution as a form of

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625 Louise Dunford and Ann Ridley, “‘No Soul to be Damned, No Body to be Kicked’[1]: Responsibility, Blame and Corporate Punishment” (1996) 24 International Journal of the Sociology of Law 1 6
627 Monica Gerber and Jonathan Jackson, ‘Retribution as Revenge and Retribution as Just Deserts’ (2013) 26 Social Justice Research 61 62
punishment was particularly well illustrated during the gathering of evidence for the Home Affairs and Works and Pensions Committees with one contributor stating “Retribution—the product of raw emotion—is an illogical and animalistic response to misfortune” and another suggesting that “Few people would disagree that justice requires that corporations be punished where death or serious injury results, where the conduct of the corporation has been seriously blameworthy in the circumstances. This is the notion of retribution—the vindication of the victim(s) in recognition of the violation of their rights.”

Khanna suggested that deterrence has, for a number of years, been considered the most appropriate and effective purpose of punishment, at least so far as corporations are concerned. MacAdams went further and stated that “…deterrence is the fundamental aim and purpose in holding corporations criminally liable,” supporting an unsigned note in the Harvard Law Review which suggested that deterrence is the major goal for corporate criminal sanctions but then going on to argue that even where the aim is deterrence, rehabilitation or incapacitation, criminal sanctions can only be applied where the offender is morally culpable. There is an argument to be made that the very threat of punishment should be sufficient deterrence for corporations to disengage from or avoid unlawful activities so long as the penalties available are truly punitive. The deterrence effect of a punishment can only be effective if it has had a significant negative impact on the organisation (or individual) found guilty but Wells suggested that the effectiveness of deterrence must be questioned and there is an ethical dimension to imposing severe penalties on one corporation pour encourager les autres. Slapper and Tombs agreed that deterrence is flawed at both a practical level and conceptually when considered in the context of “street’ or ‘traditional’” crime, but went on to suggest that it

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628 Home Affairs and Work and Pensions Committees, Draft Corporate Manslaughter Bill. HC540-II. Written Evidence. Written submission by Dr Simon Bennett
629 Ibid Written submission by Roy Thornley
633 Wells, Corporations and Criminal Responsibility op. cit. n.11, p.18
has “considerable potential” in sanctioning corporate crime. Another problem with the deterrence theory is the possibility that if the penalty is relatively insignificant, it could encourage unlawful activity by similar organisations since it will present insufficient incentive for them to change their behaviour. Incapacitation and rehabilitation both belong to the utilitarian theory of punishment, along with deterrence, but probably have less of a role to play in the punishment of corporations than retribution and deterrence although either may be intended or unintended consequences of any penalty imposed.

In many respects, the debate on whether punishment for corporate crime serves the purpose of retribution, deterrence, incapacitation or rehabilitation is less important than its potential for modifying corporate behaviour to reduce accidents and illness. Fisse identified three desired outcomes from the threat of punishment of corporations; the adoption of sound policies of compliance, the activation of existing internal disciplinary procedures and the activation of preventive operating procedures, all of which should serve to prevent corporate offending. When considering statutes enacted for the purposes of addressing various forms of corporate criminality, an unsigned note in the Harvard Law Review proposed that they were not intended primarily to punish “...morally culpable violators...”, but to deter criminal or otherwise undesirable behaviour, which goes back to the deterrence theory of punishment. When the Corporate Manslaughter and Corporate Homicide Act 2007 is considered in the context of the debate on the purpose of punishment, deterrence must be considered the primary aim but the threat of retribution in the event of a corporation being found guilty of an offence, or just deserts, will always be a consideration. How effective either deterrence or rehabilitation can ever be is questionable when there is continuing debate over whether corporations can ever be effectively punished, irrespective of the penalty imposed.

635 Slapper and Tombs, Corporate Crime op. cit. n.9, p.184
638 , 'Corporate Crime: Regulating Corporate Behavior through Criminal Sanctions' op. cit. n.13, p.1236
Schlegel identified fines as the most common approach to punishing corporate crime and the Corporate Manslaughter and Corporate Homicide Act 2007 does not move too far from that form of punishment with the main penalty for any organisation found guilty of the offence being an unlimited fine. Since this penalty can already be imposed in respect of contraventions health and safety legislation (for example, Transco fined £15 million following a gas explosion in Scotland), there does not appear to be any additional financial deterrent introduced by the Act. Offences in terms of the Act are indictable only in the High Court of Justiciary although given the severity of the offence that is probably not surprising. The Sentencing Guidelines Council suggests that the offence of corporate manslaughter or corporate homicide will normally be more serious than a health and safety offence because of the “gross breach at a senior level”. That being the case, the proposed level of fine will typically be at least £500 000 and could be “measured in millions of pounds”. In comparison, the Sentencing Guidelines Council proposes that for health and safety offences resulting in fatality, the fine would seldom be less than £100 000 and could be measured in hundreds of thousands or more. These guidelines could have the unintended consequence of reducing the level of fines currently imposed in respect of health and safety offences, irrespective of whether or not deaths have occurred as a result. Multi-million pound fines for health and safety offences have become increasingly common and fines into the hundreds of thousands of pounds are no longer unusual. The Sentencing Guidelines Council would appear to imply that fines of this level are inappropriate for health and safety offences by suggesting that even for serious offences, they should be in the hundreds of thousands rather than millions.

On 13th November 2014, the Sentencing Guidelines Council published a consultation paper for sentencing health and safety, food safety and corporate manslaughter and corporate homicide offences. The previous Sentencing Council Guidelines published in 2010 covered only corporate manslaughter, corporate homicide and health and safety offences resulting in death. In

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addition to the inclusion of food safety offences, the consultation document proposed extending the guidelines to include all health and safety offences, irrespective of the harm done and also offences committed by individuals. When discussing the level of fine to be set, the Sentencing Council reiterated the criteria laid down in Section 164 of the Criminal Justice Act 2003 where first and foremost, the seriousness of the offence must be reflected, but it must also take into account the financial circumstances of the offender. According to the Sentencing Council consultation paper, any fine must “...remove any economic gain...” and must have a real economic impact on the organisation, sufficient to persuade management and shareholders of the need to comply with legislation intended to protect workers and members of the public.

Before going on to discuss the proposals contained in the Sentencing Council consultation paper in more detail, it is worth reflecting on the use of fines to punish corporate crime. Coffee pointed out that the maximum meaningful fine imposed upon any company would be limited by its wealth, suggesting that a small company is no more threatened by a fine of $5 million than one of $500 000, if it would be unable to pay either. He described this as the wealth boundary, above which there is no deterrent effect, irrespective of the size of the fine but as discussed previously, the fine must be sufficiently large to both remove any economic gain and have real impact on the organisation. When the minimum fine recommended by the Sentencing Council for corporate manslaughter and corporate homicide offences “...will be seldom less than £500 000 and may be measured in millions...”, the wealth boundary proposed by Coffee could very well be exceeded for small companies thus removing the deterrent effect of the fine. Whilst it could be argued that the Sentencing Council did attempt to address the criticism raised by Wells, Clarkson, Slapper and Tombs and many others in respect of the low level of fines that had typically been imposed previously following fatal workplace accidents, fines as

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642 Ibid
643 Coffee Jr, "No Soul to Damn: No Body to Kick": An Unscandalized Inquiry into the Problem of Corporate Punishment” op. cit. n.384, p.390
644 Wells, Corporations and Criminal Responsibility op. cit. n.11, p.32; Slapper, 'Corporate Manslaughter: an Examination of the Determinants of Prosecutorial Policy' op. cit. n.9, p.2; Clarkson, 'Corporate manslaughter: yet more Government proposals' op. cit. n.574, p.678; Slapper and Tombs, Corporate Crime op. cit. n.9, p.204
effective punishment for corporate crime are called into question by many commentators.

In the absence of any real alternative, it is inevitable that fines will remain the most commonly applied penalty for corporate crime but the consultation document published by the Sentencing Council demonstrates continued attempts to try to achieve an optimum level that could be applied consistently for similar types of offences. In their draft guidelines published in 2014, the Sentencing Council recognised that in some cases (but, importantly, not all), the fines issued were too low to achieve the aims of sentencing and there was some inconsistency in respect of how the various factors were applied. It went on to suggest that its draft proposals would result in higher fines, particularly for the more serious offences committed by large organisations but less serious offences and offences committed by small organisations and individuals would generally remain at similar levels. This recognised that the ability to pay must be an important factor when determining an appropriate level of fine. The draft guidelines were a much more detailed approach to setting fines than the 2010 Guidelines, with four different categories of companies based on turnover and described as Large, Medium, Small and Micro. There were two categories of offence for each group, A and B, and for each offence category, a starting point and category range. For example, the starting point for a Category A Offence for a Micro company would be £450 000 with a category range of between £270 000 - £800 000, whereas for a Category A offence committed by a large company, the starting point would be £7 500 000 and the category range would be £4 800 000 - £20 000 000. Although there is a starting point indicated for each size of company and category offence, the court will still have discretion to impose a penalty well below that starting point. The proposed starting points and category ranges are well above those in the 2010 Sentencing Guidelines for large and medium companies and above those proposed for small companies. Only Micro companies had a proposed range of fines slightly less than those recommended in the 2010 Guidelines. It is worth noting that by the start of

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645 The Sentencing Council, Health and safety offences, corporate manslaughter and food safety and hygiene offences guidelines Consultation. op. cit. n.641, p.11
646 Ibid
2015, the only prosecutions taken under the 2007 Act have been taken against small or micro-sized companies.

Fines for health and safety offences follow a similar but even more detailed process based once again on the turnover, but for each category of company, the culpability is classified as into very high, high, medium and low, with each classification further broken down into four separate categories of harm. This results in sixty-four separate starting points and sixty-four category ranges for the level of fines for health and safety offences committed by organisations based on the size of the company, culpability and harm. The Sentencing Council proposals would result in fines ranging from £50 for the lowest range of fine for the lowest degree of harm and lowest level of culpability for a micro company, up to £10 million for the highest range of fine for the highest degree of culpability and the highest degree of harm. That level of fine exceeds the target level of £7 500 000 set for a corporate manslaughter offence committed by a large company. The Sentencing Council also proposed guidelines for health and safety offences committed by individuals and once again, there is a very detailed process proposed for sentencing based upon the culpability of the individual (deliberate, reckless, negligent, low culpability) and for each degree of culpability, four categories of harm, resulting in sixteen separate starting points and sixteen category ranges. Penalties could include custodial sentences, community orders and fines based on a percentage of relative weekly income. The lowest fine category proposed would be 25% - 75% of relevant weekly income with a normal starting point of 50% (Band A) and the highest fine would be 500 - 700% of relevant weekly income with a normal starting point of 600%. Custodial sentences would range from twenty-six weeks for low culpability offence with a Harm Category of 1, and up to two years for a deliberate offence with a Harm Category of 1. With the Health and Safety (Offences) Act 2008 introducing a much wider range of offences to the possibility of custodial sentences, the Sentencing Council proposed guidelines could result in a far larger number of individuals being imprisoned for health and safety offences.

As discussed previously, fines are by far the most common penalties imposed upon organisations found guilty of corporate crime but the 2007 Act introduces

647 Ibid
additional penalties, namely remedial and publicity orders. An apparently uncontroversial measure, remedial orders were introduced by Section 9 of the Act giving the court the powers to require any organisation guilty of an offence to remedy the relevant breach, to remedy matters arising from the breach that appear to the court to be the cause of death, and any deficiencies in the organisation’s health and safety policies, systems or practices. The prosecution may make an application for a remedial order and if it is granted by the court, it must specify a time by which the measures contained in the order are to be complied with and may require the organisation to provide the enforcement authority with evidence that it has been complied with. It is an indictable-only offence to fail to comply with a remedial order and the penalty, if found guilty, is an unlimited fine. Remedial orders could be considered analogous to rehabilitation, in so far as they require the corporation to ‘make good’ and avoid committing the offence in the future. Gobert suggested that correction of the circumstances leading to the offence being committed “...is so crucial that a remedial/rehabilitative probation condition should be virtually automatic unless the company could show that it had already taken adequate steps to prevent a reoccurrence of the offence.”

Remedial orders are not new in the context of workplace health and safety, Section 42 of the Health and Safety at Work etc. Act 1974 gives the courts the power to make an order remedying the matters giving rise to an offence for which a person has been convicted in addition to, or instead of any other penalty. This does not appear to have been a power extensively used by the courts; a search of the Health and Safety Executive prosecutions database does not reveal any successful prosecutions where an order to remedy matters giving rise to the offence has been made. It is likely that Improvement Notices served in terms of Section 21 of the 1974 Act have been used in preference to remedial orders as a more effective and efficient way of achieving appropriate remedy which makes Section 42 rather superfluous.

Perhaps of more interest and with more potential in the punishment of corporate offenders is the publicity order introduced by Section 10 of the 2007

Act which allows the court to make an order requiring an organisation which has been successfully prosecuted for corporate manslaughter or corporate homicide to publicise that fact in a specified manner. The “Publicity Order” can include the conviction, details of the offence, the level of fine imposed and the requirements of any remedial order imposed. Before a publicity order is made, the court must consult with any relevant enforcement authority and take into account any representations made by the prosecution or by the defence on behalf of the guilty organisation. The order must specify the period within which the order is to be complied with and the organisation may be required to supply any relevant enforcement authority with evidence, within a specified period of time that the order has been complied with. As with Remedial Orders, failure to comply with a Publicity Order is punishable by unlimited fine.

The purpose of a publicity order can only be to attach some form of stigma to corporate offending with the intention of encouraging it to modify its behaviour with Fisse suggesting that such an order is “...perhaps the quintessentially stigmatic corporate sanction...”.649 Ormerod and Taylor noted that the ability to make Publicity Orders was added to the Bill during its passage through the Lords on the basis that bad publicity may be more of a threat to large organisations than unlimited fines.650 Fisse and Braithwaite, after examining a number of high profile cases where publicity orders or similar had been made, concluded that they can be effective in some circumstances but should be “prominent” in the “armory of sanctions” available to courts.651 Schlegel was much less enthusiastic about the use of adverse publicity as punishment for corporate crime on the basis that its actual impact on corporations had not been established and it could not be shown to be either proportionate or commensurate.652 For these reasons, Schlegel did not consider adverse publicity to be an appropriate punishment for corporate crime and there must be some question over whether or not it will really have any long term impact on corporate behaviour. In her research into administrative sanctions for offences committed in the Dutch

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650 Ormerod and Taylor, ‘The Corporate Manslaughter and Corporate Homicide Act 2007’ op. cit. n.3, p.611
651 Brent Fisse and John Braithwaite, The Impact of Publicity on Corporate Offenders (SUNY Series on Critical Issues in Criminal Justice, State University of New York 1983) 314
652 Schlegel, Just Deserts for Corporate Criminals op. cit. n.639, p.160
financial sector, van Erp found that small organisations were disproportionally affected when compared to larger organisations with the latter having more resource to defend themselves against publicity orders or similar sanctions. She went on to describe publicity as a “messy sanction” suggesting that “…effects are arbitrary and may turn out to be disproportional in terms of the severity of the underlying offense”.

5.7 The Controversy

The Corporate Manslaughter and Corporate Homicide Act 2007 has had a difficult and rather lengthy gestation and in its final form, is not without controversy. The whole purpose of the Act has been called into question; for example, before going on to generally welcome the Act, Ormerod and Taylor suggested that some commentators may view it as “...making a symbolic statement about corporate responsibility, which it will struggle to fulfil in practice...” further suggesting that any corporate manslaughter cases would be far from straightforward. It would be difficult to be more dismissive of the 2007 Act than Wells who prefixed it with the descriptor “...curdled sauce...” having previously expressed some concern that the focus on ‘senior management failure’ retained an “…affinity with identification liability...” which was the main reason for the failure of corporate gross negligence manslaughter cases prior to its introduction. Gobert did not quite go as far as Wells in associating ‘management failure’ with the identification doctrine, but he did suggest that proving management failure was the cause of the death would be much easier to achieve in a small organisation than in a large one. Ormerod and Taylor also commented on the need to associate the deaths, at least in part, with the “relative contribution” of an individual or group of individuals at senior

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654 Gobert, ‘The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?’ op. cit. n.592, Welham, Corporate Manslaughter and Corporate Homicide: A Manager's Guide to Legal Compliance op. cit. n.531, Almond, Corporate Manslaughter and Regulatory Reform op. cit. n.503, p.171
655 Ormerod and Taylor, ‘The Corporate Manslaughter and Corporate Homicide Act 2007’ op. cit. n.3, p.590
656 C. Wells, ‘Corporate crime: opening the eyes of the sentry’ (2010) 30 Legal Studies 370 386
657 Gobert, ‘The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?’ op. cit. n.592
management level but they described the process of doing so as a “qualified aggregation principal”. What is clear is that it is not enough to demonstrate that a death arose from work activities as a consequence of corporate failure; it will still be necessary to show that a group of individuals also failed in some respect to prevent the death from occurring.

One of the most significant omissions from the Act and one that received significant criticism was the prosecution of individual directors and other senior managers which met with disappointment in many quarters and ran contrary to the original proposals contained in the Home Office consultation document. In addition to taking action against individual directors or senior managers in relation to the offence of corporate manslaughter, the consultation document proposed that individuals who could be shown to be responsible for a person’s death should be disqualified from acting in a management role in Great Britain. The pressure group, Families Against Corporate Killers, in one of the more extreme responses to the publication of the bill suggested that it was “fatally flawed” in so far as it did not hold any individual liable and what they described as “the only penalty” was an unlimited fine which already existed for breaches of existing health and safety legislation. Wright also pointed out that the 2007 Act holds corporations to account for deaths arising from their activities, but not the individuals within the corporation whose negligence, consent or connivance resulted in the offence being committed although, as discussed previously, they could still be guilty of the offence of gross negligence manslaughter.

One interesting, and almost certainly unintended, consequence of the exclusion of individual liability in the 2007 Act was pointed out by Antrobus who argued that, on the increasingly popular assumption that targeting the individuals who run the business is more of a deterrent than targeting the business itself, the

658 Ormerod and Taylor, ‘The Corporate Manslaughter and Corporate Homicide Act 2007’ op. cit. n.3, p.593
659 The Home Office, Reforming the Law on Involuntary Manslaughter: The Government’s Proposals op. cit. n.8, p.19, 20
661 Wright, ‘Criminal liability of directors and senior managers for deaths at work’op. cit. n.3, p.953
authorities may develop a more aggressive approach to pursuing gross negligence manslaughter charges against individual directors in addition to any corporate manslaughter or corporate homicide charges laid against their companies.\textsuperscript{662} The Health and Safety (Offences) Act 2008 also provides additional opportunity for custodial sentences to be imposed on individuals at all levels of an organisation following breaches of the health and safety legislation. The exclusion of individual liability from the 2007 Act could result in a more imaginative approach to obtaining custodial sentences for senior managers but once again, small organisations will be much more affected by this possible change in prosecution strategy.

In some respects, the failure to extend the Act to include individuals along the lines discussed previously perpetuates the two-tier approach that existed prior to its introduction. Directors and senior managers of large organisations will, to all intents and purposes, be exempt from criminal liability, at least for manslaughter or culpable homicide, while similar individuals in small organisations are still likely to be charged for common law offence of gross negligence manslaughter or culpable homicide, whether or not their organisations are charged with corporate manslaughter and, as will be discussed below, this has proved to be the case. The Act seems to have introduced little additional incentive for company executives to take a greater interest in health and safety although the symbolic importance of the legislation should not be ignored. Almond suggested that the Act’s main failing is that it is “…too corporate in nature to impact meaningfully on the individual decisions of directors and not corporate enough to herald a true sea change in the law”.\textsuperscript{663}

On the face of it, there is little for large organisations to fear from the introduction of this Act although the threat of a Publicity Order may focus the minds of some senior executives. Although not intended as a response to the crime of manslaughter, the Health and Safety (Offences) Act 2008 introduced the possibility of custodial sentences for a wide range of health and safety offences including those where deaths occurred as a result. As a consequence of the 2008 Act, it is possible that company directors, chief executives and other

\textsuperscript{662} Simon Antrobus, ‘The criminal liability of directors for health and safety breaches and manslaughter’ (2013) Criminal Law Review 309 311
\textsuperscript{663} Almond, \textit{Corporate Manslaughter and Regulatory Reform} op. cit. n.503, p.32
senior managers could be imprisoned for up to two years where deaths arise from work activities even where there is insufficient evidence for either corporate or gross negligence manslaughter. The relationship between the 2007 and 2008 Acts will be discussed further in the Conclusions.

Some commentators have also suggested that the focus on deaths arising from work activities is too narrow. Although death is obviously the most severe of all the possible outcomes from corporate behaviour it is still, in statistical terms, relatively uncommon particularly when compared to the incidence of serious injury or ill-health. In 2013/14, the Health and Safety Executive (HSE) recorded 133 fatal accidents to workers (including self-employed) and a further 264 accidents to members of the public arising from work activities (including 194 relating to incidents on railways).664 Although each fatality will have a devastating impact on friends and family, the UK record for fatal accidents is generally good when compared to other countries but death is only one possible consequence of incidents in the workplace. A range of injuries and diseases are required to be reported to the Health and Safety Executive in terms of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations and in 2013/14, the HSE recorded 18 877 “Major or Specific Injuries” and 58 716 “Over-7-day Injuries” and it should be noted that the HSE suspects that fewer than half of all non-fatal injuries are actually reported even though it is an offence not to do so.665 These statistics would tend to support Gobert’s proposal that a crime of corporate grievous bodily harm would be much more effective in encouraging organisations to review and perhaps change their safety culture.666

Although much more difficult to associate with a particular activity or employer, occupational illness and disease accounts for many more fatalities each year than workplace accidents. The HSE estimates that in 2013/14, 13 000 people died as a consequence of respiratory illness or cancer caused by workplace

664 Health and Safety Executive, Statistics on fatal injuries in the workplace in Great Britain 2014. Full-year details and technical notes 2014) 3
666 Gobert, ’The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?’ op. cit. n.592, p.432
exposure to substances or chemicals and a further 1.2 million were made ill. Although the Corporate Manslaughter and Corporate Homicide Act 2007 does not preclude prosecution for deaths arising from occupational illness and disease, it is difficult to see how the Act can be applied in many such circumstances. The chronic nature of most of these diseases and the potentially long incubation periods between exposure and symptoms appearing (up to fifty years in the case of mesothelioma caused by exposure to asbestos fibres), will make it almost impossible for the police or Crown Prosecution Service to build a case against organisations held responsible for deaths arising from chronic exposure to substances. That is not to say that all illness and disease would be excluded from prosecution under the 2007 Act; there have been successful prosecutions under the 1974 Act taken against organisations held responsible for deaths arising from Legionnaires’ disease and while there have been no prosecutions for corporate manslaughter in these circumstances, so long as the sources of the bacteria can be identified and deaths have arisen as a consequence of exposure, there is no reason why such a prosecution would not be successful. Having said that, successful prosecutions where death has occurred as a consequence of occupational illness or disease will only ever be an insignificant proportion of the total number of deaths they cause each year.

Prosecution for corporate manslaughter or corporate homicide will be undertaken by the Crown Prosecution Service in England and Wales and the Procurator Fiscal in Scotland following investigations carried out by the police supported by the Health and Safety Executive or other relevant enforcing authority. The relationship between the police, the Crown Prosecution Office and the Health and Safety Executive (and other enforcing authorities) in prosecutions for corporate manslaughter will be fundamental to the effective prosecution of the more complicated cases and guidance from the Ministry of Justice, whilst making it clear that any investigations for corporate manslaughter will be undertaken by the police, they will be expected to call upon the expertise of appropriate enforcing authorities, including the Health and

Safety Executive. 668 Once again, this is contrary to the proposals included in the Home Office consultation document which recommended that, at least in England and Wales, the Health and Safety Executive and possibly other enforcing authorities should investigate and prosecute the new offences in addition to the more traditional approach of the police and Crown Prosecution Service prosecuting for manslaughter. 669 The main justification for giving the police the investigation role for the 2007 Act was the concern expressed that, at least in some circumstances, there would be parallel investigations carried out by the police and the enforcing authorities but extensive experience had been accrued in these exact circumstances prior to the introduction of the 2007 Act. It was relatively common for both police and the appropriate enforcing authority to undertake joint investigations in relation to workplace deaths and well-established protocols were already in place for such occasions. The guide to the Act published by the Ministry of Justice makes reference to a range of protocols in existence in the various home nations of the UK to facilitate liaison between the police, the Crown Prosecution Service (or equivalent) and the enforcing authorities. 670 Wright was critical of the decision to allocate the main investigatory role for the 2007 Act to the police, pointing out that they may have different priorities to the Health and Safety Executive. 671 Instead, he proposed the establishment of a specialist, multi-disciplinary team to investigate deaths arising from work activities. This proposal does not appear to have been discussed elsewhere and there is very little likelihood of it being adopted.

The inclusion of public bodies, charities and other non-profit making organisations has resulted in comment from both sides of the argument. 672 While there may be little sympathy for corporations which profit at the expense of safety, there is a question about whether or not it is appropriate to put organisations such as hospitals, clinics, trades unions, charities, etc. in the same

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668 Ministry of Justice, *A guide to the Corporate Manslaughter and Corporate Homicide Act* op. cit. n.18, p.18
669 The Home Office, *Reforming the Law on Involuntary Manslaughter: The Government’s Proposals* op. cit. n.8, p.17
670 Ministry of Justice, *A guide to the Corporate Manslaughter and Corporate Homicide Act* op. cit. n.18, p.18
671 Wright, ‘Criminal liability of directors and senior managers for deaths at work’ op. cit. n.3, p.966
672 Gobert, *The Corporate Manslaughter and Corporate Homicide Act 2007 - Thirteen years in the making but was it worth the wait?* op. cit. n.592, p.415

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category. There can be no distinction made between organisations that cause death because the profit motive trumps the safety imperative, and the non-profit organisations that cause death through incompetence, mismanagement, underfunding or any other reason. The victim is no less dead and their family no less bereaved because they were killed by the failure of a non-profit organisation rather than a large, multi-national company and it must be noted that at least some of the accidents referred to at the start of this Chapter were caused by organisations in the public sector at the time. It should be noted that the breadth of application, in particular to public bodies, has been welcomed by some commentators with concern being expressed by the extent of the exemptions offered to them.673

5.8 Conclusion

The Corporate Manslaughter and Corporate Homicide Act 2007 is not a particularly long piece of legislation and in many respects it is very narrow in its application, which could be considered both a strength and weakness, and has been seen as such by various commentators. Its impact on organisations will be discussed in detail in the final Chapter but it could be argued that it has achieved what it set out to, that is, removed the explicit requirement to satisfy the identification doctrine which proved to be such an insurmountable hurdle when prosecuting larger organisations for corporate manslaughter.

As a piece of legislation, it has a number of complex arrangements for determining its application, particularly to public bodies, determining whether or not a duty of care exists, what constitutes a “gross” breach of the duty of care, and so on. As a number of commentators have observed, except in the most straightforward of cases achieving a conviction could prove difficult. Although there had been a number of prosecutions by the end of 2015, none of them could be described as contentious or difficult. It is fair to say that the 2007 Act has not been subjected to any extreme tests.

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673 Ormerod and Taylor, 'The Corporate Manslaughter and Corporate Homicide Act 2007' op. cit. n.3, p.597
Perhaps a more fundamental question is how the 2007 Act is a significant improvement upon the Health and Safety at Work etc. Act 1974, particularly following the introduction of the Health and Safety (Offences) Act 2008 with unlimited fines and the option of custodial sentences for individuals found guilty of an offence. As discussed previously in this Chapter, the 2007 Act is not health and safety legislation but there would be very few circumstances where the Health and Safety at Work etc. Act 1974 would not apply, at least to some extent. Obviously the health and safety legislation does not include a manslaughter offence but perhaps it is not the punishment of organisations for manslaughter that was the main cause for concern following the accidents discussed previously in this Chapter, but the apparent immunity of the senior managers of these organisations not just from the charge of manslaughter, but any individual responsibility for their occurrence. The 2007 Act does not address this particular concern, indeed it explicitly excludes individuals from the offence of corporate manslaughter and whilst the common law offence of gross negligence manslaughter can still be used, senior managers in the largest organisations would almost certainly be shielded from the offence by the layers of management between them and the accident whereas similar post-holders in the smallest organisations would be exposed to the charge. In this particular respect, the 2007 Act cannot be considered an effective remedy.

The next Chapter will examine the nature of crime and regulation in more detail and in particular, the continuing debate over what is ‘true’ crime and what is regulatory, and whether or not there is any actual difference between them. In many respects, as a piece of ‘true’ criminal law, the 2007 Act addresses some of the perceptions held by some people in the legal field that health and safety is a regulatory issue, rather than criminal. Whether or not it makes any difference in modifying the behaviour of large organisations will be discussed in the final Chapter.
6.0 Crime and Regulation

6.1 Introduction

Towards the end of the twentieth century and start of the twenty-first, there was a consensus that the regulatory approach to workplace safety was failing to effectively punish large organisations held responsible for causing deaths as a consequence of their activities - corporate killing. This perception was at least partly attributable to the regulatory nature of health and safety legislation where breaches were not considered to carry the same stigma as ‘true’ criminal offences. Its emphasis on prevention rather than punishment or retribution could also be attributed to its regulatory nature. The use of the common law offences of gross negligence manslaughter and culpable homicide proved no more successful, at least against larger organisations. This, perhaps inevitably, led to the criminalisation of the offence of corporate killing with the introduction of the Corporate Manslaughter and Corporate Homicide Act 2007 which offered a very different approach to the regulatory system previously relied upon to improve workplace safety.

Starting with the impact of the 2007 Act, this Chapter will examine the consequences of criminalising what would have been traditionally considered regulatory offences in the context of the sense of criminal and regulatory law which, of course, change to reflect changing circumstances, perceptions and societal attitudes. In addressing the sense of regulation and criminal law, the practical implications for the distinction between each will become more apparent.

The introduction of the Health and Safety (Offences) Act 2008 with its wider range of penalties, particularly custodial sentences for many more offences, has the potential to change the perception of what is categorised as regulation and perhaps go some way towards answering the question of whether or not there is actually a real distinction between criminal and regulatory law, or if it is actually an artificial construct.
6.2 Impact of the Corporate Manslaughter and Corporate Homicide Act 2007

The first case prosecuted under the Act was against Cotswold Geotechnical Holdings in respect of the death of junior geologist Alexander Wright when a trench he was taking soil samples in collapsed. The company director, Peter Eaton, was also charged with gross negligence manslaughter and there were various other health and safety charges laid against the company in respect of the accident. The company was found guilty of corporate manslaughter and fined £385 000, payable over ten years. Because of his ill-health, the charge of gross negligence manslaughter was not pursued against the company director. The conviction and the size of the fine were subsequently the subject of an unsuccessful application for leave to appeal to the Court of Appeal. Although the leave to appeal was dismissed, it is interesting to note that the appellant’s legal team pointed out that the fine was 250% of the company’s turnover and whilst the merits or otherwise of the fine are not in question here, it does show how small a company it was. Whilst the offence of corporate manslaughter was found proven in the case of Geotechnical Holdings, it was never going to properly test the effectiveness of the 2007 Act which was intended “...to try and gain traction on large and medium sized companies”, a description that could not be applied to this company. Since Peter Eaton would almost certainly have been identifiable as ‘the controlling mind’ of the company on the basis of the identification doctrine, there is little doubt that gross negligence charges could have been brought prior to the 2007 Act.

Since that first case, there have been a further seventeen cases in England and Wales brought by the Crown Prosecution Service under the Corporate Manslaughter and Corporate Homicide Act 2007, making a total of eighteen to the end of June 2015. Of those eighteen cases, eight are ongoing, eight defendants have been found guilty and two defendants have been found not guilty. The maximum fine imposed was £500 000 and the average was just under

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674 R. v Cotswold Geotechnical Holdings Limited 2011 WL 2649504 (Crown Court)
675 R v Cotswold Geotechnical (Holdings) Ltd [2011] EWCA Crim 1337 (Court of Appeal, Criminal Division)
676 Editorial, ‘The First of Many’ IIRSM Newsletter (June 2008) 1
677 Personal Communication from the Crown Prosecution Service dated 29 June 2015
£260 000, significantly below the starting point of £450 000 proposed by Sentencing Council for Category A offences for micro companies discussed in chapter five. The average fine is below the lowest end of the category range of between £270 000 and £800 000. Further information on cases brought in England and Wales and Northern Ireland can be found in Appendix A. In the same timeframe, the Crown Office and Procurator Fiscal Service for Scotland has raised no prosecutions under the Corporate Manslaughter and Corporate Homicide Act 2007.

Following the death of a woman in October 2012 during childbirth, Maidstone and Tunbridge Wells NHS Trust and two anaesthetists were respectively prosecuted for corporate and gross negligence manslaughter. It is perhaps one of the most important cases since the Act was introduced, being the first involving a large public sector organisation. The victim had given birth by caesarean section but subsequently suffered from serious bleeding. She underwent a further operation under general anaesthetic to remove placental tissue from her uterus and after that procedure, no further bleeding was observed. What happened then is subject to some uncertainty with the anaesthetist and an operating department practitioner stating that they had seen some signs of revival but the nurse responsible for the two operating theatres in the maternity unit not seeing or hearing any response.

If there was a recovery, it did not continue and the victim’s breathing became irregular to such an extent that she required ventilation, which the anaesthetist carried out using an oxygen bag and face mask. This continued for around forty minutes and a consultant anaesthetist, the first defendant, Dr Cornish, was called in and proceeded to do a number of things, including reviewing the victim’s oxygen saturation, which gave no cause for concern, and various other tests, all of which were standard practice and carried out in an appropriate manner. The following hours saw various consultants and other individuals

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681 Ibid
visit the victim as her condition did not improve and then started to deteriorate. Around three hours after manual ventilation was commenced, she suffered a cardiac arrest and died around an hour later.

Gross negligence manslaughter charges were brought against the anaesthetist, Dr Nadeem Azeez and the consultant anaesthetist, Dr Errol Cornish, and a charge of corporate manslaughter was brought against Maidstone and Tunbridge Wells NHS Trust. Dr Azeez left the UK before the trial started and did not return for it. After hearing seven days’ worth of evidence, the judge, the Honourable Mr Justice Coulson acquitted both remaining defendants on the grounds that they had no case to answer. In a long and detailed ruling, The Honourable Mr Justice Coulson considered all aspects of the charges against both Dr Cornish and the Trust. He concluded that the actions of Dr Cornish did not breach the duty of care owed to the victim, and even if there was a breach, it could not be considered a gross breach. There was nothing in Dr Cornish’s treatment of the victim that could have caused or significantly caused her death there was no evidence to suggest that she was at serious or obvious risk of death as a consequence of that treatment. Accordingly, there was no case for Dr Cornish to answer.682

Moving on to the case against the Trust, an interesting aspect of Mr Justice Coulson’s ruling was his discussion in respect of senior management, where he identified the “senior management” with individual roles, either the CEO, medical director or clinical director. This seems to revert to the previous identification doctrine which had been an obstacle in so many corporate manslaughter cases prior to the 2007 Act. Having said that, he rejected the submission made by the Trust that the case should be stopped because the “...precise tier or precise individuals involved...” had not been identified.683 Part of the case against the Trust was a breach of duty in the appointment of both Dr Azeeez and Dr Cornish. The Honourable Mr Justice Coulson could find no evidence to suggest that there was any case against the Trust on the basis of the appointment of either anaesthetist. Similarly, the case against the Trust was

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682 Ibid
683 Ibid
not made in respect of appraisal or ongoing professional supervision in respect of Dr Azeez.

Where The Honourable Mr Justice Coulson did find evidence of a breach of duty was in respect of the day in question. He considered that the supervision of Dr Azeez on that day was unclear even though there was a supervisor named on the rota but he went on to say that there was no evidence to suggest that Dr Azeez did not know who his supervisor was, and even if he did not know, there was no evidence that this failure had any effect on the victim’s care. Although there may have been a breach of duty of care, The Honourable Mr Justice Coulson held that there was no evidence that it was a gross breach of the duty of care, nor did it materially contribute to the victim’s death.

Before concluding that there was no case to answer against either defendant, The Honourable Mr Justice Coulson made some interesting comments about the Crown’s assertion at the beginning of the case that in order for their case against the Trust to “...get off the ground...” they had to establish gross negligence manslaughter against one or both of the anaesthetists. He disagreed with the Crown’s argument, stating that each charge was independent of the other, it would be possible for both anaesthetists to be found not guilty of gross negligence manslaughter but the trust to be found guilty of corporate manslaughter, and vice-versa.

The implications of the Maidstone and Tunbridge Wells case will not be fully appreciated for some time but it is inevitable that it will influence any future corporate manslaughter charges against large public sector organisations but importantly, it does illustrate the challenges that any corporate manslaughter case will face where the circumstances are not clear-cut. It could be argued that whilst the victim should not have died and the standard of care was inadequate, the failures by both the doctors and the Trust could never have been considered “gross” and perhaps this was perhaps a set of circumstances that might have benefited from a different approach, a view supported by Barnard who described the prosecution as “…dangerously speculative...”.  

Within a week or two of the dismissal of the charges against Maidstone and Tunbridge Wells and Cornish, a case with some similarities was decided at Nottingham Crown Court, but with a very different outcome. In 2012, an elderly resident of Autumn Grange Care Home in Nottingham died as a consequence of the very poor care she received. The home was operated by Sherwood Rise Limited which was charged with corporate manslaughter and the company director was charged with gross negligence manslaughter. Both the company and director pleaded guilty to the respective charges, with the former being fined £300 000 and the latter imprisoned for three years and two months and disqualified from holding a company directorship for eight years. The care home manager was sentenced to one year imprisonment, suspended for two years, after being found guilty of breaches of health and safety offences, and disqualified from being a company director for five years.

This case was notable as the first successful prosecution for corporate manslaughter in the health care sector. In that respect, it is similar to the Maidstone and Tunbridge Wells case but the similarities end there. The scale of the organisations was hugely different and the evidence of gross breach of duty of care was very much apparent in the Autumn Grange case. One other obvious difference between the two cases was the guilty pleas from both Autumn Grange and its Director.

Even taking these two high profile cases into account, there would still appear to be a considerable gap between the number of potential corporate manslaughter/corporate homicide cases and the number actually prosecuted. The Health and Safety Executive collects data on fatal injuries and from April 2008 to March 2014, six hundred and fifty-five employees, three hundred self-employed workers and two-thousand two hundred and seventy members of the public were recorded as suffering a fatal injury as a consequence of work activities. Between January 2010 (when the first prosecution took place) and December 2015, there had been a total of eighteen corporate manslaughter

prosecutions in England, Wales and Northern Ireland and none in Scotland (see Appendix A). Given the very lengthy periods experienced so far between deaths and prosecution, it is possible that there may be a few from that period in the pipeline but it must be assumed that here wouldn’t be more than a handful. It should be noted that two-thousand one hundred and ninety-four of the deaths to members of the public occurred in the service sector and the Health and Safety Executive estimates that around three-quarters of those deaths were railway fatalities, including suicides. From 1st October 2013, the requirement to report railway suicides was removed. However, even if all fatal injuries to members of the public and self-employed workers were removed from the statistics, there still seems to be a significant disconnect between the numbers of worker suffering fatal injuries whilst at work and the number of corporate manslaughter cases brought over a significantly longer period of time. Whilst not all the fatal injuries to employees would satisfy the criteria for a corporate manslaughter or corporate homicide charge, it must also be assumed that more than eighteen of the recorded fatal injuries to self-employed workers and members of the public would meet the criteria.

As discussed previously, the Health and Safety Executive does not prosecute for the consequences of a contravention but for its breach, with the consequences only being relevant during sentencing (although they would obviously influence enforcement action taken by the Executive). This makes it impossible to determine how many prosecutions were taken by the Health and Safety Executive where a fatal injury was the outcome of the contravention but the total number of prosecutions taken and success rate can be found on its website.\(^\text{687}\) Between 2009/10 and 2013/14, the average number of proceedings initiated each year by the Health and Safety Executive was 565, with an average of 109 further cases initiated by local authorities for health and safety offences over the same period. The average annual success rate, that is, defendants found guilty of at least one contravention, was 94% for the Health and Safety Executive and slightly higher at 97% for local authorities. It can only be conjecture and there is no evidence to support it, but the relatively high prosecution rate by the Health and Safety Executive and local authorities could

\(^{687}\text{Ibid}\)
be one reason why enforcement of the 2007 Act was eventually allocated to the police and the Crown Prosecution Service. It is impossible to know if proceedings for corporate manslaughter/corporate homicide would be more common if the Health and Safety Executive was responsible for its enforcement but it would not be unreasonable to conclude that it probably would be, given its track record for prosecution of health and safety offences.

The discussion so far in this Chapter has focussed on the relationship between the 2007 Act and health and safety offences but it must recognised that it applies more widely than just deaths arising from what would be considered health and safety contraventions. The 2007 Act applies where death arises from “...the way in which its activities are managed or organised...” so could include those where the health and safety legislation would not be applicable, for example, the provision or sale of harmful food or other substances. Having said that, all eighteen cases brought under the 2007 Act would fall under the general description of workplace health and safety and so far, it seems to being used as an adjunct to the more general health and safety legislation.

It is difficult see any particular pattern in respect of the deaths referred to the Crown Prosecution Service for proceedings for corporate manslaughter. To illustrate this, the June 2015 edition of the Safety and Health Practitioner reports on two health and safety prosecutions, both involving the death of a worker. Both accidents are fairly typical of the type reported month after month but it is difficult to understand why neither was subject to prosecution for corporate manslaughter and one in particular would appear to satisfy all of the criteria for such a prosecution where a worker was killed after being struck by a fragment from a disc which exploded after being incorrectly fitted to a handheld grinder. The Health and Safety Executive investigation discovered a long history of similar incidents caused by the company allowing the use of inappropriate combinations of grinders and discs and a lack of training and understanding of the correct use of discs by workers. The hazards associated with the incorrect use of discs and grinders are well known and there has been extensive guidance published over the years highlighting them and advising on

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688 Lauren Applebey, ‘Steel firm hit with £150K fine after fatality’ (2015) Safety and Health Practitioner 111
their safe use. The company was fined £150 000 for breaching S2(1) of the 1974 Act and ordered to pay £24 000 in costs. This accident is, by no stretch of the imagination, unusual or exceptional but the question must be asked what makes it different from *R v. Geotechnical (Holdings) Ltd* discussed previously in this Chapter. There was clearly a duty owed to the victim and in light of the company’s history of similar accidents and the failure to put in place effective control measures, it must be considered a gross breach of that duty and the actions of the senior management were, without doubt, a substantial element of the breach. In many respects, it could be argues that this company was more liable for the death of the worker than Geotechnical Holdings, so why was a prosecution for corporate manslaughter not initiated?

In the same edition of Safety and Health Practitioner, a prosecution against Pirelli Tyres was reported where it was found guilty and fined £150 000 when a worker died after being trapped in an industrial autoclave. After sentencing, the HSE said “...Pirelli had failed to identify the autoclave as a confined space posing a serious risk. There were therefore no measures in place, such as instructions or signs, to prevent access to the autoclave. There was also no system for checking the autoclave before the door was shut and the operating cycle was started.”689 Once again, on the face of it, there would certainly appear to be sufficient evidence to support corporate manslaughter proceedings and it would have been the largest organisation to be prosecuted since the introduction of the 2007 Act.

It is not clear why so few prosecutions have been taken under the 2007 Act, although it could be argued that it is still a relatively new piece of legislation, it would be expected that by 2014/15 there would have been a significant acceleration in the number of cases, which does not appear to have happened, or at least in any meaningful way. The allocation of investigation to the police and enforcement to the Crown Prosecution Service in England Wales must have some influence on the approach to corporate manslaughter cases and the guidance published by the National Liaison Committee for the Work-related deaths protocol will certainly not encourage prosecutions to be initiated. The

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guidance has a number of signatories including the Association of Chief Police Officers, the Crown Prosecution Service and the Health and Safety Executive and is intended “.to assist the police, enforcing authorities and prosecutors in the joint investigation and where applicable, the prosecution of cases in relation to deaths in the workplace”. Section 4 of the guidance discusses the decision making process when considering prosecution for corporate manslaughter and gross negligence manslaughter. Strangely, it seems to conflate both offences even though they are very different and some of the advice seems to be rather contradictory. For example, the guidance states “Negligence by a number of people cannot be aggregated to mean that all together their conduct fell far below the required standard. All those suspected of breaching the law must be considered individually.” Whilst this is indeed the case for gross negligence manslaughter, it is not the case for corporate manslaughter and would imply a return to the identification doctrine which caused so many cases to fail in the past. It is possible that the quoted passages are intended to apply only to gross negligence manslaughter cases and the guidance does go on to discuss specific requirements for the corporate manslaughter offence including the involvement of the organisation and the role of senior management, but that only comes after the emphasis on the need to establish individual responsibility. On the basis of this guidance, which will be used by the police and other enforcing agencies that perhaps do not have the appropriate experience, it is hardly surprising that so few fatal accidents have been referred to the Crown Prosecution Service for corporate manslaughter charges. It must also be assumed that increased concern over terrorism will have had an impact on police priorities and it is possible that corporate manslaughter/corporate homicide will not have the level of priority originally anticipated.

The Health and Safety (Offences) Act 2008 could potentially have a more significant impact on organisations than the 2007 Act although it does not cover such a wide a range of activities. Unlike the 2007 Act, it applies only in the same circumstances as the Health and Safety at Work etc. Act 1974 but as discussed elsewhere in this dissertation, the number of potential cases that

690 National Liaison Committee for the Work-related deaths protocol (England and Wales), Work-related Deaths Protocol: Practical guide (England and Wales) (Health and Safety Executive 2015) 3
691 Ibid
would fall outside its scope will be very few. A very short piece of legislation, the 2008 Act was introduced with much less fanfare than the Corporate Manslaughter and Corporate Homicide Act 2007, perhaps due to its ‘regulatory’ nature, but it introduced the possibility of custodial sentences for many more health and safety offences and in the five year period ending in March 2015, the Health and Safety Executive prosecutions database recorded twenty-one decisions which resulted in a prison or suspended prison sentence. It is too soon to draw any meaningful conclusions from the number of health and safety prosecutions resulting in a prison sentence, suspended or otherwise, but it does suggest that courts are willing to impose custodial sentences for what could be considered regulatory offences. With the 2008 Act extending the range of penalties for both organisations and individuals found guilty of a health and safety offence, including unlimited fines and imprisonment, the raison d’être for the Corporate Manslaughter and Corporate Homicide Act 2007 must be called into question. That question will be addressed in the final Chapter but before then, some of the concerns in respect of the 2007 Act will be examined in more detail.

As discussed earlier in this Section, there would appear to be no discernible pattern for the corporate manslaughter cases initiated by the Crown Prosecution Service other than all of the companies prosecuted have been small or medium-sized, with the exception of Maidstone and Tunbridge Wells, as discussed previously. Examples of what would, on the face of it, appear to be clear cases of corporate manslaughter have not been pursued by the Crown Prosecution Service and as discussed elsewhere in this document, concern has been expressed by various commentators about some of the cases that have been prosecuted. In R v. Lion Steel Equipment Limited, the company was charged with corporate manslaughter and three directors charged with gross negligence manslaughter following the fatal fall of an employee through a fragile roof. The company and directors were also charged with a range of health and safety offences, including, in respect of the directors, Section 37 of the Health and Safety at Work etc. Act 1974. The judge determined that it would be unfair for

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693 R v. Lion Steel Equipment Ltd (2012) Unreported (Manchester Crown Court)
the corporate manslaughter charge to be heard at the same time as the individual gross negligence manslaughter charges and ordered it to be severed from the indictment. The gross negligence manslaughter charges against the three directors were dismissed by the judge and Lion Steel Equipment Limited pleaded guilty to the charge of corporate manslaughter with all other charges either dismissed or left on file. It is interesting to note that the offer of a guilty plea for the corporate manslaughter charge on condition that the individual gross negligence manslaughter charges against the three directors being dismissed was made some months prior to the court hearing but was rejected by the Crown Prosecution Service. Finally, the judge was very critical of the length of time between the victim’s death in 2008 and the case being heard, in particular the three years it took for the prosecuting authorities to bring charges.

The decision to prosecute Lion Steel for corporate manslaughter and its three directors for gross negligence manslaughter follows the pattern set by the very first corporate manslaughter case where the company and its director were also charged with corporate and gross negligence manslaughter. A search of the Safety and Health Practitioner using the term “gross negligence manslaughter” revealed a number of prosecutions against individuals occupying various positions in organisations, some were associated with a corporate manslaughter charge but others were not although almost all had parallel prosecutions for health and safety offences. It would certainly appear that the introduction of the Corporate Manslaughter and Corporate Homicide Act 2007 has had the effect of a significant increase in gross negligence manslaughter proceedings in respect of workplace deaths even if the number of corporate manslaughter cases has been relatively small.

The changes in sentencing introduced by the 2008 Act has, according to the Health and Safety Executive prosecutions database, resulted in prison sentences being imposed in three cases where Section 37 of the Health and Safety at Work etc. Act 1974 was breached, and one case involving a breach of Section 7.694 Whilst this could not be considered particularly significant, and the numbers are certainly far too few to draw any particular conclusions, they do indicate a

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694 At the end of June, 2015
willingness of courts to impose a custodial sentence on company directors and others. There is concern expressed about the use of gross negligence manslaughter and Section 37 of the 1974 Act charges being taken against company directors and others, but in combination with multi-million pound fines imposed following breaches of health and safety legislation, it is difficult to see how the Corporate Manslaughter and Corporate Homicide Act 2007 provides any significant advantage over the more traditional health and safety legislation in encouraging organisations to carry out their undertakings in a safer way, particularly following the introduction of the Health and Safety (Offences) Act 2008 other than the possibility of a ‘criminal’ rather than ‘regulatory’ conviction. The remainder of this Chapter will examine the conflict between criminal and regulatory offences and its implications for corporate killing.

6.3 Crime

There has been much discussion in this thesis about regulation and ‘true’ crime, and having established the Health and Safety at Work etc. Act 1974 (and the Health and Safety (Offences) Act 2008) as regulation and the 2007 Act as criminal, it is now necessary to consider what these categorisations actually mean for workplace safety. Before that can be done, the terms must be defined but defining criminal law is, as Herring suggested, “...surprisingly difficult...” and over the years there have been many attempts to define, or possibly more appropriately, describe what it is. Criminal law prohibits “...behaviour that represents a serious wrong against an individual or some fundamental social value or institution” . Ashworth pointed out that criminal law extends beyond “serious wrong” including many examples of what could be considered relatively minor offences that have little, or no stigma attached to them. The concept of ‘stigma’ has been used to distinguish between criminal and regulatory offences and will be discussed in more detail later in this Chapter.

695 In particular, see Antrobus, ‘The criminal liability of directors for health and safety breaches and manslaughter’ op. cit. n.662
696 Herring, Criminal Law op. cit. n.538, p.9.
697 A. Ashworth, Principles of Criminal Law (6th edn, Oxford University Press 2009) 1
Lamond suggested that crimes are public wrongs the community is responsible for punishing, although not necessarily wrongs against the public itself.\textsuperscript{698} It could be argued that this follows on from Williams who stated a “...crime (or offence) is a legal wrong that can be followed by criminal proceedings which may result in punishment”\textsuperscript{699} although Herring pointed out that this is a circular argument - what came first, the crime or the criminal procedures?\textsuperscript{700} Williams addressed and dismissed this argument on the basis that a crime is established by the fact that the wrong can be followed by criminal proceedings therefore criminal proceedings determine the crime.\textsuperscript{701} Commenting on Williams, Farmer agreed that “Crime is defined by the legal consequences of the act...” supporting Devlin, who stated that “…criminal law is not a statement of how people ought to behave; it is a statement of what will happen to them if they do not behave”.\textsuperscript{702, 703} This leads on to the question of who determines the consequences of any particular course of action or behaviour. In \textit{Proprietary Articles Trade Association v. Attorney-General for Canada}, it was held that “...the domain of criminal jurisprudence can only be ascertained by examining what acts at any particular period are declared by the State to be crimes, and the only common nature they will be found to possess is that they are prohibited by the State and that those who commit them are punished.”\textsuperscript{704} This would imply that any behaviour will be a crime if so determined by the State. This definition of crime was subsequently qualified by Lord Atkin who proposed that there must be “…some evil or injurious or undesirable effect upon the public against which the law is directed”.\textsuperscript{705} He went on to suggest areas appropriate for criminal law, including “...public peace, order, security, health, morality...” making clear that this list is not exclusive but would cover most circumstances.
The role of government in determining crime and criminal behaviour is supported by Clarkson et al who suggested that in most cases, the decision to criminalise certain behaviour or actions happens as a political response to pressure groups or perceived public opinion, in effect politicians decide what is criminal behaviour.\textsuperscript{706} As Slapper succinctly put it, “crime is anything that the state has chosen to criminalise”.\textsuperscript{707} This can lead to the situation where “Statutory additions to the criminal law are too often made on the simple principle that ‘there ought to be a law against it’”.\textsuperscript{708} Baldwin supported this view when discussing punitive approaches to regulation which “...may be driven by recently emergent public appetites for blame as much as by considered thoughts on regulatory strategy”.\textsuperscript{709} This would suggest that whilst politicians decide what criminal behaviour is (or will be) this decision is reached with at least a consideration of what the public opinion is. It could certainly be argued that the Corporate Manslaughter and Corporate Homicide Act 2007 falls into this category as will be discussed in more detail later. There are other examples of public opinion driving criminal law including the Dangerous Dogs Act 1991 and much of the child protection legislation introduced since the Soham murders in 2002.

Having considered what criminal law is and where it comes from, before it can be considered in the context of regulation it is necessary to consider its purpose, which is typically to punish those found guilty of its contravention.\textsuperscript{710} The purpose of punishment can include retribution, or just deserts, as discussed in a previous chapter and it may be considered the main justification for criminal law although there are other outcomes of criminal prosecution, including deterrence, either for the guilty party or for others who may be tempted into the same unlawful behaviour.\textsuperscript{711} Ashworth proposed that there are two dimensions for the justification for criminal law and punishment, a “...deserved response to culpable wrongdoing...” and as a deterrence to others.\textsuperscript{712} Deterrence

\textsuperscript{706} C.M.V. Clarkson, H.M. Keating and S.R. Cunningham, Clarkson and Keating Criminal Law: Text and Materials (6th edn, Sweet & Maxwell 2007) 3
\textsuperscript{707} Slapper, Blood in the Bank: Social and legal aspects of death at work. op. cit. n.515, p.10
\textsuperscript{708} Devlin, ‘Morals and the Criminal Law’ op. cit. n.703, p.382
\textsuperscript{710} Williams, Textbook of Criminal Law op. cit. n.347, p.36; Ashworth, Principles of Criminal Law op. cit. n.697, p.18; Herring, Criminal Law op. cit. n.538, p.4
\textsuperscript{711} Herring, Criminal Law op. cit. n.538, p.30
\textsuperscript{712} Ashworth, Principles of Criminal Law op. cit. n.697, p.17
lets “...one person suffer in order to instil fear into others” and as discussed in Chapter Five, it must be considered an important outcome of any action taken against corporations in respect of health and safety offences. Deterrence can be personal, intended to dissuade the guilty party from repeating the unlawful behaviour or, perhaps more relevant to corporate crime generally, where it is intended to dissuade other people or organisations from participating in the unlawful behaviour.

As discussed previously, retribution and deterrence are not the only justifications for criminal law, dangerous criminals may be removed from society making it, in theory, a safer place, and rehabilitation of the offender may prevent reoffending at a later point in time. Retribution and deterrence are perhaps less important when it comes to corporate crime but they are possible consequences of any sentence imposed under criminal law. Before the distinction between crime and regulation can be examined in more detail, it is necessary to examine the concept of regulation, with particular reference to worker protection.

6.4 The Nature of Regulation

…it is next to an impossibility to alter a general bad custom in any nation, without a general regulation, because of inveterate bad dispositions and discouragements, with which the first beginnings of reformations are always attended.

Much of the previous discussion in this thesis has focussed on the distinction between regulatory and criminal law with the more traditional health and safety

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715 Herring, Criminal Law op. cit. n.538, p.30
716 Ibid
717 A. Fletcher, 'Two Discourses concerning the Affairs of Scotland' 1698) <http://oll.libertyfund.org/title/1222> accessed 16 April
legislation falling firmly in the former category and the 2007 Act in the latter. Why this matters, if it does, will be discussed in this section which will explain the role regulation has played in the past and will inevitably play in the future to protect the health and safety of people affected by work activities but before that can be considered, it is necessary to define what it is and how it differs from other forms of control. The Oxford English Dictionary has a number of definitions for “regulation” including:-

1. The action or fact of regulating (in various senses of REGULATE v.); an instance of this. Also: the state of being regulated.
2. A rule or principle governing behaviour or practice; esp. such a directive established and maintained by an authority.\(^718\)

Regulate is defined as:-

1. To control, govern, or direct, esp. by means of regulations or restrictions.
2. To bring under control; to reduce to order.
3. To correct through regulation.
4. To control, modify, or adjust with reference to some principle, standard, or norm; to alter in response to a situation, set of circumstances, etc.\(^719\)

From these definitions, it can be seen that the term ‘regulation’ is very wide in its application and will cover almost every form of control, governance or direction. Most people will have an opinion on what ‘regulation’ is but there are almost as many interpretations of the term as there are researchers in the field as illustrated in the following paragraphs.\(^720\)

Morgan and Yeung suggested that ‘regulation’ is “…notoriously difficult to define with clarity and precision,…”, a view supported by Moran who stated

\(^{718}\) "regulation", ‘OED Online’ (Oxford University Press, 2010) <http://dictionary.oed.com/cgi/entry/50201390> accessed 15 April, 2010
\(^{720}\) Baldwin and Cave, Understanding Regulation. Theory, Strategy and Practice op. cit. n.359, p.1
that it is a “notoriously inexact word”\textsuperscript{721}. Perhaps the simplest definition is that given by Hood et al., “…governmental interference with market or social processes to control potential adverse consequences to health”.\textsuperscript{722} Collins adopted a broad approach to ‘regulation’ and he used the term to “…describe any system of rules intended to govern the behaviour of its subjects” suggesting that law is only one of many types of social regulation including “…custom, convention and organised bureaucracies.”\textsuperscript{723} He did recognise that the term can be used in a narrower sense, particularly when applied to the control of markets where ‘regulators’ will endeavour to prevent distortion and its undesirable effects, but also protect the participants.

In common with other commentators, Braithwaite adopted the analogy of rowing and steering to describe the three distinct stages of the regulatory state.\textsuperscript{724} Prior to the nineteenth century civil society was mainly responsible for both rowing and steering with the state’s involvement being restricted to providing protection to the populace against major crime and maintaining the laws of contract. From the nineteenth century to the mid-late twentieth century, the state became almost entirely responsible for rowing and steering (although he suggested that the state was much weaker in steering than rowing) but towards the end of the twentieth century, the state becomes responsible for steering while civil society takes on the responsibility for rowing.\textsuperscript{725}

Black took a different view to Moran and proposes that regulation “…is that aspect of governance which is concerned with changing (or maintaining) the behaviour of others in order to attain an identified goal,…”.\textsuperscript{726} This would imply a much more active involvement than suggested by Moran. It also fitted more comfortably with the regulatory approach taken by the Health and Safety

\textsuperscript{723} Hugh Collins, Regulating Contracts (Oxford University Press 1999) 7
\textsuperscript{725} Braithwaite, ‘The New Regulatory State and the Transformation of Criminology’ op. cit. n.724, p.224
Executive. Black went on to discuss the structure of agencies formed in the nineteen-seventies, including the Health and Safety Commission, describing them as having the “stamp of corporatism” by including “…representatives of labour, capital and the state…” in their governance bodies.\textsuperscript{727} She compared them to more modern regulators where the emphasis is on consumer panels although it must be noted that many of the modern regulators were established to protect consumer interest which is different from protecting worker safety.

Scott suggested that regulation can be thought of as “…any process or set of processes by which norms are established, the behaviour of those subject to the norms monitored or fed back into the regime, and for which there are mechanisms for holding the behaviour of regulated actors within the acceptable limits of the regime (whether by enforcement action or some other mechanism)”.\textsuperscript{728} Again, this would seem to be more in line with Black than Moran, implying a more active approach than the latter.

Baldwin \textit{et al} identified three different forms of regulation, a set of authoritative rules, usually with some mechanism to ensure compliance, steering of the economy by the efforts of state agencies and finally, all mechanisms of social control.\textsuperscript{729} There is overlap between these different forms but workplace safety would normally fall under the first category although Baldwin \textit{et al} pointed out that it would also fall under the second category and, of course, it could also fall under the final category. Importantly, the third category will encompass the influence that organisations have in the policy making process and its implementation.\textsuperscript{730}

Ogus described regulation as “…fundamentally a politico-economic concept…” which perhaps more explained its origins rather than what it is and how it works.\textsuperscript{731} He went on to distinguish between ‘social’ and ‘economic’ regulation, with the former including health and safety, environmental and consumer protection and the latter dealing with ‘industries with monopolistic

\textsuperscript{727} Ibid 256
\textsuperscript{728} C. Scott, ‘Analysing Regulatory Space: Fragmented Resources and Institutional Design’ (2001) Public Law 329 331
\textsuperscript{729} R. Baldwin, C. Scott and C. Hood (eds), \textit{A Reader on Regulation} (Oxford Readings in Socio-Legal Studies, Oxford University Press 1998) 3
\textsuperscript{730} Ibid
\textsuperscript{731} A. I. Ogus, \textit{Regulation. Legal Form and Economic Theory}. (Oxford University Press 1994) 1
tendencies’. He suggested social regulation arose from two types of market failure; in an unregulated market where individuals may not have sufficient information about the quality of goods or services offered by suppliers resulting in their preferences not being met, and market transactions having an adverse effect on individuals not directly involved in them. The focus of this Chapter is on social rather than economic regulation although there will inevitably be overlap between the two types, at least so far as public interest is concerned.

Ogus described different regulatory forms based on the extent of state intervention as shown in figure 6.1

![Figure 6.1 - Regulatory Forms](image)

Health and safety regulation has mainly taken the form of standards, with a range of criminal sanctions available for non-compliance, although there are areas where high intervention is the norm, for example licensing in the case of working with asbestos or manufacturing and storing explosives. Within the context of the forms of regulation identified by Baldwin, Morgan and Yeung further identified three main theories of regulation; public interest, private interest and institutionalist.

There are two aspects to the public interest theory of regulation. Perhaps the most relevant to worker safety and the one that could be considered to encompass the traditional view is regulation for the benefit and security of the

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732 Ibid
733 Ibid
734 Morgan and Yeung, *An Introduction to Law and Regulation. Text and Materials.* op. cit. n.721, p.16
Selznick stated that regulation is the “...sustained and focused control exercised by a public agency over activities that are valued by a community” which perhaps illustrates at least part of the distinction between it and the ‘criminal’ law. Although Selznick took a narrow view of what regulation is, his views conformed to the public interest theory and its intended outcome. The alternative approach is economic welfare where regulation follows on from market failure. This concept of public interest regulation following market failure has been touched upon previously in this Chapter. In a perfect capitalist society, markets should govern themselves but in the event of a market failure, private law should be able to provide an appropriate remedy. In reality, private law has not always provided a satisfactory remedy to market failures resulting in the need for regulation in the public interest. Much of the research carried out in the nineteen-eighties and nineteen-nineties focussed on regulation of the (then) newly privatised industries, the City and the professions. Majone argued that the single justification for regulation was “...improving the efficiency of the economy by correcting specific forms of market failure such as monopoly, imperfect information, and negative externalities”. In this respect, regulation fulfils a function beyond that normally associated with criminal law although failure to comply with regulation can have the same or similar consequences to committing more traditional crimes. Hantke-Domas identified two aspects of public interest, that is, perception and concept. He suggested that the perception of public interest is associated with the “...realisation of political and moral values” while the concept provides the basis for deciding disputes “...within the realm of the community’s interest”.

738 Ogus, Regulation. Legal Form and Economic Theory. op. cit. n.731, p.29. 30
739 Giandomenico Majone, 'The rise of the regulatory state in Europe' (1994) 17 West European Politics 77 79
740 Hantke-Domas, 'The Public Interest Theory of Regulation: Non-Existence or Misinterpretation?' op. cit. n.735, p.186
What is now referred to as the public interest theory was generally accepted as the only explanation of regulation until the early nineteen-seventies when Stigler first argued that regulation was not primarily for the public benefit but mainly served the narrow self-interests of industry and commerce. The private interest theory (also called the Chicago or positivist theory) provided an explanation why so many supposedly competitive industries, in particular transport, banking, finance and telecommunications, had, at that time, price and entry regulation amongst other anticompetitive controls. The private theory of regulation gained popularity amongst supporters of privatisation and deregulation in the late nineteen-seventies and nineteen-eighties. Increased competition by means of privatisation of public sector monopolies and deregulation of private monopolies (for example, airlines, freight haulage, telecommunications, etc.) was partly justified on the basis of the private theory of regulation. Braithwaite stated that the domination of the private interest theory of regulation as proposed by the Chicago School had come to an end by the nineteen-nineties and that it had not produced privatisation and deregulation but privatisation and regulatory growth, as discussed previously in this Chapter.

The private theory of regulation goes some way to explaining regulatory capture, which occurs when it is in the interests of the regulated to be regulated, at least under that particular regime. McLean suggested that regulatory capture could arise through two routes, the regulations come into force for the benefit of the regulated or they are subsequently captured by the regulated at some point in

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742 Majone, 'The rise of the regulatory state in Europe' op. cit. n.738, p.82
744 Braithwaite, The Oxford Handbook of Political Institutions op. cit. n.743, p.409
745 Majone, 'The rise of the regulatory state in Europe' op. cit. n.738, p.83
Regulatory capture includes circumstances where the regulatory administration or enforcing authority is captured by the regulated industry. Stone cast doubt over the extent of regulatory agency capture arguing that interests are too diverse to allow it to take place either frequently or for any length of time. Maikkai and Braithwaite found little evidence of systematic regulatory capture in their study on nursing home regulation agencies. Whilst there is little evidence of systematic regulatory capture, one of the consequences of the Clapham Train Crash was the transfer of health and safety for railways in the UK from the Railway Inspectorate to the Health and Safety Executive. This would imply at least some concern over regulatory capture and a similar situation arose following Piper Alpha when offshore safety was transferred from the Department of Energy to the Health and Safety Executive as a consequence of a perceived conflict of interest which would almost certainly result in regulatory capture. Although somewhat outside the scope of this research, the role of the US Minerals Management Service in the Deepwater Horizon disaster illustrates the dangers of regulatory agencies working too closely with the regulated industry. As a consequence of severe staff shortages and a culture of accommodating the interests of the industry, the Minerals and Management Service was an almost perfect example of a captive regulator and has been severely criticised as a consequence.

In addition to concerns over regulatory capture, the independence of regulators is also at risk from political interference. Although Moran suggested the establishment of the Health and Safety Commission and Health and Safety Executive set them free from the “...outcomes of partisan, majoritarian politics”, he was subsequently scathing about their performance in the nineteen-

746 McLean, ‘The origin and strange history of regulation in the UK: three case studies in search of a theory ’ op. cit. n.174, p.3
747 Alan Stone, Regulation and its Alternatives (Politics and Public Body, Congressional Quarterly Press 1982) 229
748 Ibid
749 T. Mikkai and J. Braithwaite, A Reader on Regulation (Oxford University Press 1998)
750 Robert L Glicksman, ‘Regulatory Blowout: How Regulatory Failures Made the BP Disaster Possible, and How the System Can Be Fixed to Avoid a Recurrence’ (2010) GW Law Faculty Publications & Other Works Paper 608, 23
eighties. He implied that this was at least partly due to regulatory capture where the Health and Safety Executive, and the regulated sector found common cause in maximising production rather than ensuring safety. He suggested that this regulatory capture contributed to accidents such as Piper Alpha although in that particular case, the enforcing authority was the Department of Energy and offshore safety was subsequently transferred to the Health and Safety Executive. Black saw the creation of the Health and Safety Executive and Health and Safety Commission as part of a “renewed move to establish regulatory bodies” in the 1960’s and nineteen-seventies.

The failure of the Health and Safety Executive to adopt non-governmental rules and standards was criticised by Black. In particular, she referred to the Responsible Care initiative which was established by the chemical industry to develop a transnational industry-based regime for the management of health, safety and environmental issues. It also included certification and verification but the programme was not adopted by the Health and Safety Executive when setting its own guidance, or when determining compliance with statutory requirements. Black suggested that this “…illustrates the dangers of assuming that legal norms will always trump other operating norms…”. The failure of the Health and Safety Executive to adopt the standards referred to by Black was contrary to the approach proposed by Robens, namely the increased use of industry guidance and codes of practice, but it does fit with the ‘command and control’ regulatory form discussed previously in this Chapter.

6.5 ‘Real’ Crime

An important part of this research is to examine the perception that the traditional ‘regulatory’ approach to controlling health and safety in the workplace has failed to prevent deaths arising from work and work activities, or perhaps more pertinently, failed to properly punish those considered responsible

752 Ibid
753 Black, ‘The Decentred Regulatory State?’ op. cit. n.726, p.258
754 Ibid
for such deaths. The Corporate Manslaughter and Corporate Homicide Act 2007 was introduced to address this apparent failure and as a piece of legislation it is very much perceived as ‘criminal’ in nature and is quite distinct from the regulatory approach to workplace safety that went before it. The concepts of crime and regulation has been discussed previously but the distinction between a ‘criminal’ and ‘regulatory’ offence, if there is one, has not been fully explored. The remainder of this Chapter will consider the concept of ‘real’ or ‘true’ crime as the basis for such a distinction.

As discussed previously, the difference between criminal and regulatory offences has been the subject of much speculation. Hildebrandt suggested that the distinction can be traced to the concepts of what she referred to as ’justice’ and ‘police’ (or administration), in particular their separation as individual domains of government power in the eighteenth and nineteenth centuries. The present day association of criminal offences with ‘justice’ was made by Lacey who included it as one of the intrinsic values attached to ‘real crime’ which also includes fairness, right and wrong. Hildebrandt traced the distinction back to medieval times, with crimina resulting in corporal punishment and contraventions resulting in fines. Crimina were “violations of the royal peace”, whereas contraventions were “violations of administrative rules”. From this, Hildebrandt proposed that the difference between criminal and regulatory offences was “…a historical artefact rather than an ontological fact”. It should be noted that Hildebrandt’s research focused on continental Europe and her findings do not necessarily apply directly to England, Wales and Scotland.

In her conclusions, Hildebrandt proposed that regulatory offences have their origins in rules implemented by democratic institutions, as opposed to criminal offences which have their origin in pre-existing rules which imposed obligations on individuals to one another, prior to them being criminalised by the state. Whilst this distinction may have been appropriate in the past, it is not sustainable in the twenty-first century where an ever increasing number of

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757 Ibid
758 C. Parker and others (eds), Regulating Law (Oxford University Press 2004) 145
759 Hildebrandt, ‘Justice and Police: Regulatory Offenses and the Criminal Law’ op. cit. n.756, p.50
760 Ibid
criminal offences have their origins in parliament (for example, the dangerous dogs’ legislation referred to previously).

A different approach is taken by Stafford who drew a distinction between prosecutions taken by the police and what he referred to as “private prosecutions”. 761 He defined “private prosecutions” quite simply as any prosecution not taken by the police. This would include prosecutions taken by the Health and Safety Executive, local authorities, Environment Agency, fire authorities, education authorities, and so on. This group would be normally considered to be “regulatory” authorities and this distinction has been used to differentiate between “criminal” and “regulatory” law, on this basis it is not the offence that determines its nature but the body or organisation responsible for its prosecution. This could justify the decision to have the Corporate Manslaughter and Corporate Homicide Act 2007 investigated and prosecuted by the police, rather than the Health and Safety Executive and it also affirms that distinction between the “criminal” 2007 Act and the regulatory health and safety legislation.

Mackenzie and Green blur this particular approach to distinguishing between regulatory and criminal when discussing the Dealing in Cultural Objects (Offences) Act 2003. 762 They clearly saw this Act as an attempt to regulate participants in the antiquities trade and referred throughout the paper to the “regulated” and “regulator” even though the Act did not establish a regulating body (Customs and Excise were able prosecute offences in certain circumstances). If the role of Customs and Excise is put to one side, this Act would surely fall under the definition of criminal law discussed in the previous paragraph, in so far as the police would appear to prosecute offences. This is just one of many examples of legislation which could fall into either camp, crime or regulation, which in itself suggests the distinction is rather artificial.

When comparing the Corporate Manslaughter and Corporate Homicide Act 2007 to the Health and Safety (Offences) Act 2008 and other specific health and safety legislation, the enforcing authority does indicate a difference, with the

761 Richard J. Stafford, Private Prosecutions. Practice & Procedure in the Criminal Courts (Shaw & Sons 1989) xxxix
former enforced by the police and the latter (mainly) by the Health and Safety Executive. At its simplest, this approach would suggest that the police would enforce ‘true’ crime while other organisations (including the Health and Safety Executive) would enforce “regulatory” crime, the determining factor being the enforcement agency rather than the offence. Again, this distinction does not appear particularly robust since there are “regulators” that will enforce criminal law (for example, Her Majesty’s Revenue and Customs) and there are circumstances where police will enforce what clearly falls under the category of regulation.

Wells suggested that, rather than any distinction between what she referred to as “public safety” or “other” criminal law, historical and administrative factors would determine whether or not a piece of legislation would fall to any particular regulatory agency (or any regulatory agency at all) to enforce.\(^\text{763}\) Following this line of argument, it is not possible to establish whether an offence is regulatory or criminal on the basis of the agency responsible for prosecuting it. When discussing the concept of public welfare as a mechanism for distinguishing between regulation and criminal law, with the former being mainly concerned with public safety, Wells pointed out that crimes such as murder, assault, wounding, etc., cannot be separated from the concept of public safety and there had been increasing criminalisation of activities that could affect public safety but were previously outside legal control.\(^\text{764}\) The implication is that whether an offence is regulatory or criminal cannot be determined on the basis of public welfare or public safety but the 2007 Act supports the argument that there has been increasing criminalisation of certain types of activities which were either excluded from the law altogether or subject to regulation. The Corporate Manslaughter and Corporate Homicide Act 2007 could be associated with protecting public safety but unlike health and safety legislation, it would not be described as regulation for the reasons stated previously. This confirms Well’s view that it is administrative and/or historical factors that will determine whether a piece of legislation falls to a particular regulator to enforce, rather than its fundamental nature.

\(^{763}\) Wells, Corporations and Criminal Responsibility op. cit. n.11, p.7

\(^{764}\) Ibid
Stafford pointed out that many of the prosecutions taken by regulators involve crimes of strict liability, and generally do not require *mens rea* although there are a number of offences where *mens rea* may be absent but they are still prosecuted by the police.765 Stafford provided the example of drunk driving where, assuming there are no other offences committed by the driver, the offence is one of strict liability. This would suggest that *mens rea* in itself is not sufficient to establish whether an offence is regulatory or criminal. In general, offences requiring *mens rea* will be considered true crime (even then, there may be exceptions) but not all strict liability offences are regulatory as demonstrated with the offence of drunk driving.766 The concept of strict liability is important when considering true and regulatory criminal law and will be discussed later in this Chapter.

The distinction between criminal and regulatory law was discussed by Lacey who suggested that criminal lawyers have focussed on “real crime” (her quotation marks) while treating regulatory offences as marginal.767 This supports the argument that some sections of the legal profession see regulation as something lesser than true or real crime. Lacey associated “real crime” with those offences requiring *mens rea*. Her approach was similar to that of Stafford when defining private prosecution but it has the same problems with some strict liability offences which would normally fall under the criminal rather than regulatory category. Lacey went on to define regulation as “...a practice which has the intention or effect of controlling, ordering, or influencing the behaviour” although she questioned her own broadening of regulation in terms of “analytic integrity and fit with linguistic usage”.768

Although offences prosecuted by regulators would, in most cases, be strict liability in nature, there may be circumstances where consent, connivance or negligence of the defendant in allowing the offence to be committed could be important in determining guilt, as well as any subsequent penalty. Section 37 of the Health and Safety at Work, etc., Act 1974 states that where an offence has

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766 Clarkson, Keating and Cunningham, *Clarkson and Keating Criminal Law. Text and Materials* op. cit. n.706, p.207
767 Parker and others (eds), *Regulating Law* op. cit. n.758, p.144
768 Ibid

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been committed by a body corporate but can be attributed to the consent, connivance or negligence of “...any director, manager, secretary or other similar officer...”, then that person is also guilty of the offence. This would suggest that mens rea must be demonstrated for the offence to have been committed, at least where the fault is one of consent or connivance. The 1974 Act is generally considered regulatory, rather than true criminal law but it still includes this element of mens rea, rather than the more typical strict liability approach associated with regulation.

Whether or not a particular offence needs mens rea has been subject to much debate and discussion. There is a general presumption that mens rea is required unless the wording of the statute suggests otherwise, in which circumstances strict liability will apply. Lord Scarman in Gammon Ltd v. Attorney-General of Hong Kong stated the following propositions for determining whether or not mens rea is required:

1. there is a presumption of law that mens rea is required before a person can be held guilty of a criminal offence;
2. the presumption is particularly strong where the offence is "truly criminal" in character;
3. the presumption applies to statutory offences, and can be displaced only if this is clearly or by necessary implication the effect of the statute;
4. the only situation in which the presumption can be displaced is where the statute is concerned with an issue of social concern, and public safety is such an issue;
5. even where a statute is concerned with such an issue, the presumption of mens rea stands unless it can also be shown that the creation of strict liability will be effective to promote the objects of the statute by encouraging greater vigilance to prevent the commission of the prohibited act.769

The debate over strict liability is one of controversy and disagreement best illustrated by Reid who suggested that “One’s view of strict liability depends on one’s view of the purpose of criminal law and the principles of a criminal justice

769 Gammon Ltd. v Attorney General of Hong Kong [1985] AC 1 (Privy Council (Hong Kong))
process”, resulting in as many views as there are commentators.\(^{770}\) Strict liability removes the need for intent to be proven; it only requires the act to have been carried out, irrespective of the mental state of the perpetrator.\(^{771}\) Ashworth described strict liability offences as those “...which a person may be convicted without proof of intention, knowledge, recklessness or negligence”.\(^{772}\) They are typically associated with environmental and public protection, including workplace safety but as mentioned previously, the Health and Safety at Work etc. Act 1974 may require the mental state to be established in some circumstances so it cannot be assumed that health and safety legislation, \textit{per se}, is always strict liability in nature.\(^{773}\)

Herring identified four justifications for strict liability in criminal law; protection of the public, ease of proof, strict liability offences are not really criminal and the Human Rights Act.\(^{774}\) Protection of the public, which Herring suggested was the main justification, is also viewed by other commentators as important in the creation of strict liability offences.\(^{775}\) The threat to public health, safety, morals or order is such that \textit{mens rea} need not be demonstrated by the prosecution.\(^{776}\) This concept of public protection or public welfare has been discussed previously in this Chapter and there is clear historical link between strict liability and public protection or welfare.

Schwenk argued that most regulations (if not all) subject to a penalty are ‘public welfare offences’, and accordingly do not require \textit{mens rea} to be established.\(^{777}\) The concept of public welfare offences was discussed at length by Sayre, from their origin in Great Britain in the nineteenth century through to the United States in the 1920’s and ‘30s.\(^{778}\) He proposed that a public welfare

\(^{772}\) Ashworth, \textit{Principles of Criminal Law} op. cit. n.697, p.160
\(^{773}\) Reid, ‘Strict Liability: Some Principles for Parliament’ op. cit. n.770, p.174
\(^{774}\) Herring, \textit{Criminal Law} op. cit. n.538, p.82
\(^{776}\) \textit{R. v. Lemon} [1979] AC 617 (House of Lords)
\(^{778}\) Sayre, ‘Public Welfare Offences’ op. cit. n.623
offence was one that did not need *mens rea* to be established for a guilty verdict to be reached. He suggested that the need to establish *mens rea* for an offence would be determined by two factors, its character and the nature of the penalty.  

This clear distinction between public welfare offences and true crime was challenged by Wells as discussed previously. “Strict liability offences are easier for the prosecution to prove”, where *mens rea* can be difficult to establish, a prosecution for a strict liability offence can succeed if the act can be established irrespective of the intent. This is clearly an advantage when prosecuting an organisation, where establishing *mens rea* has proved difficult, if not impossible, and one that the 1974 Act, supported by the Health and Safety (Offences) Act 2008 has over the Corporate Manslaughter and Corporate Homicide Act 2007 when dealing with the unlawful behaviour of organisations.

It could be argued that health and safety legislation has gone even further in that an injury arising from a workplace accident is proof that an offence has been committed. It is up to the employer or person having control of premises to prove that they had taken all reasonably practicable measures to prevent the accident occurring. Referred to as the reverse burden of proof, it has been the subject of some debate over the years. Making reference to the case of *R. v. Chargot and others* which involved the death of a dump-truck driver, Spencer expressed concern about this apparent reverse burden of proof, “So in other words, wherever an industrial accident occurs the employer is guilty unless he can talk his way out of it”. In this case, the driver’s employer, the main contractor for the construction site, and a director of the main contractor were prosecuted for various offences in terms of the 1974 Act. Lord Hope concluded “… where a person sustains injury at work, the facts will speak for themselves. Prima facia, his employer, or the person by whose undertaking he was liable to be affected, has failed to ensure his health and safety. Otherwise there would have been no accident”.

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779 Ibid
780 Wells, *Corporations and Criminal Responsibility* op. cit. n.11, p.7
781 Herring, *Criminal Law* op. cit. n.538, p.82
782 *R. v. Chargot Ltd (trading as Contract Services) and others* op. cit. n.304
The question of whether or not strict liability offences are truly criminal has been discussed at length and Herring suggested a justification for strict liability is that such offences are not really criminal. Although a defendant can be acting entirely reasonably, there is no “grave injustice” if he or she is convicted (although the introduction of the Health and Safety (Offences) Act 2008 may change this view). He pointed out that the distinction between a regulatory and truly criminal offence is irrelevant when it comes to trial and punishment, a point made previously in this Chapter and supported by Williams who put forward the view that “Magistrates may allow the traffic offender to preserve a modicum of his self-respect by standing in front of the dock instead of in it; yet he can often be tried on indictment, and he is subject to the same types of punishment as common criminals”.

The final justification for strict liability offences put forward by Herring was the Human Rights Act, although his argument was less a justification than a confirmation that strict liability offences are not prohibited by the Human Rights Act and Article 6 of the European Convention on Human Rights. Making reference to key judgements, Herring confirmed that strict liability offences do not infringe Article 6 of the Convention.

Wells used the inchoate mode to differentiate between what she terms “conventional offences” and “regulatory offences”. Although a conventional offence can take an inchoate mode, it is normally one of a pair with the partner being result-based, for example, attempted murder and murder. Regulatory offences will often stop at the inchoate stage, what follows being irrelevant to the offence. The inchoate nature of health and safety offences is illustrated by R. v. Board of Trustees of the Science Museum where it was held that it was only necessary to show that risk to health could exist for an offence to be committed in terms of Section 3(1) of the Health and Safety at Work etc., Act 1974. It was not necessary to prove that injury was caused, or even that the risk to health did exist. In this case, discussed in more detail in Chapter Three, the Board of Trustees of the Science Museum were successfully prosecuted for

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784 Herring, Criminal Law op. cit. n.538, p.82
785 Williams, Textbook of Criminal Law op. cit. n.347, p.322
786 Herring, Criminal Law op. cit. n.538, p.83
787 Wells, Corporations and Criminal Responsibility op. cit. n.11, p.5,6
788 R. v. Board of Trustees of the Science Museum op. cit. n.303
having a cooling tower contaminated with *Legionella Pneumophila*, the bacterium responsible for Legionnaires Disease. Although only presenting a risk when inhaled, it was held that it was not necessary to prove that any member of the public had been exposed to it as a result of the operation of the cooling tower, nor even that it had escaped into the atmosphere; the presence of the bacterium and the potential for it to escape was enough for risk to be established. This could be important in distinguishing between the 1974 Act and the 2007 Act where an offence is only committed when a death has occurred, but there could be breach of the former where there is the potential of a fatality, even if it has not occurred.

Using the distinction between safety and harm, Wells argued that regulation strives for the former but criminal law punishes the latter.\(^{789}\) Looking at regulation and criminal law more broadly than Wells, Baldwin *et al* reached a similar view and suggested that the former is intended to encourage particular activities or to change behaviour, whilst the latter is focussed on punishing wrongdoing although they accepted that not everyone found it a convincing argument.\(^{790}\) This is illustrated by the case of *R. v. Board of Trustees of the Science Museum* where the offence is exposing members of the public to risk, so the emphasis is on ensuring safety rather than punishing harm. Even if deaths had occurred and could be directly attributed to the state of the cooling towers, the nature of the offence would not change (although any penalty applied may take into account its consequences and additional offences may have been committed, for example, gross negligence manslaughter). Once again, this distinction illustrates the difference between the 2007 Act and the 1974 Act, with the former punishing a particular type of harm and the latter striving for safety.

Clarkson *et al* argued that offences of the nature discussed in the previous paragraphs are not inchoate since they do not require a second offence to give them meaning, in effect, an offence cannot be inchoate if there is no substantive offence.\(^{791}\) Conspiracy, incitement, and attempt are inchoate

\(^{789}\) Wells, *Corporations and Criminal Responsibility* op. cit. n.11, p.6

\(^{790}\) Baldwin, Scott and Hood (eds), *A Reader on Regulation* op. cit. n.729.

\(^{791}\) Clarkson, Keating and Cunningham, *Clarkson and Keating Criminal Law. Text and Materials* op. cit. n.706, p.471
offences but in themselves they are incomplete, there must be a subsequent crime or offence, for example, murder, fraud, etc. - the substantive offence. 792 This view is also put forward by Ashworth who discussed the need for a substantive offence which does not exist in the example of R. v. Board of Trustees of the Science Museum. Health and safety offences will not normally fall under any of the categories of inchoate offences described by Clarkson et al and Ashworth, that is, conspiracy, incitement or attempt and are, in themselves, substantive offences. This somewhat contradicts Wells, although there are similarities between inchoate offences and health and safety offences of the type described in the previous paragraphs, the main one being that harm is not caused but the offence has still been committed.

A further category of offence exists, endangerment offences, which share some of the characteristics of inchoate offences, most notably that physical harm need not have occurred for the offence to be committed. 793 The most significant difference between endangerment and the various inchoate offences is that the former does not need a subsequent offence to exist; it is a crime in itself but only where there is a potential for harm. Alvesalo et al pointed out that many health and safety offences do not require actual or even “abstract” endangerment to exist, they exist in the absence of any consequences. 794 Clarkson et al puts some health and safety offences in the category of endangerment but it is certainly the case that they would not all fit there, particularly the administrative offences such as not having a safety policy. 795

6.6 Criminal or Regulatory?

Regulation has also been described as “quasi” rather than “real” crime with the term being used to describe offences committed by “...white collar criminals

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792 Ashworth, Principles of Criminal Law op. cit. n.697, p.437
793 Clarkson, Keating and Cunningham, Clarkson and Keating Criminal Law. Text and Materials op. cit. n.706, p.540
795 Clarkson, Keating and Cunningham, Clarkson and Keating Criminal Law. Text and Materials op. cit. n.706, p.541
pursuing their business interests and those committing road traffic offences.”

Lacey et al did not support this distinction and went on to argue that it is difficult to justify any conceptual difference between injuries or loss arising from breaches of regulation and injury or loss arising through theft or assault. Fitzgerald identified “real” crimes as those that are *mala in se*, and “quasi” crimes as those that are *mala prohibita*. In many respects, this distinction is similar, if not identical, to that discussed previously of *crimina* and *contravention*. Like Hildebrandt, Fitzgerald also traced the origins of this distinction to mediaeval times, or even earlier. Travers suggested that almost all criminal offences prior to the Industrial Revolution were *mala in se* and it was the advent of the Industrial Revolution that created the need for *mala prohibita* offences. This would imply that there was no moral blame attached to the offence of failing to protect workers and the public from hazardous factory conditions. Interestingly, Fitzgerald suggested that employers have a moral duty to protect the health and safety of employees but he went on to point out that, with the introduction of factories legislation, offences have “...descended into a wealth of detail impossible to deduce from the general moral principle...”.

Fitzgerald focused on moral blame when distinguishing between “real” crime and “quasi” crime, and suggested that since the latter involves “little if any moral blame”, they should only carry minor penalties and trial by jury “...is probably inappropriate...”. He then went on to identify a further category of offence, a form of *mala prohibita* which “...falls midway between real crime and the pure technical offence.” In effect, there are some offences which, whilst not *mala in se*, are too serious to be subject to “trivial” penalty.

This approach to crime and whether it is ‘true’ or ‘regulatory’ in nature has been questioned by many commentators. Dennis suggested that classifying crime by *mala in se* or *mala prohibita* is problematic and not particularly robust for two reasons; relying on the” moral quality” of the act is far too ambiguous.

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797 P.J. Fitzgerald, ‘Real Crimes and Quasi Crimes’ (1965) 10 Natural Law Forum 21 21
798 Hildebrandt, ‘Justice and Police: Regulatory Offenses and the Criminal Law’ op. cit. n.756
800 Fitzgerald, ‘Real Crimes and Quasi Crimes’ op. cit. n.797, p.44
801 Ibid
and it would also be contestable in court. Some health and safety or environmental offences could be as morally reprehensible as other, more traditional crimes and certainly some of the incidents discussed in Chapter Five and elsewhere in this document would be described as such. Almond argued that trying to establish the *mala in se/mala prohibita* distinction on the basis of content is “...doomed to failure...” as a consequence of the variety of criminal offences, many of which prohibit some form of wrongdoing that impacts on public welfare. This would suggest that any distinction between true and regulatory crime on the basis of *mala in se* and *mala prohibita* is increasingly difficult to sustain but it is used to support the implication that regulatory crime is somehow less serious than true crime.

The last word on the difference between *mala in se* and *mala prohibita* must go to Jeremy Bentham who, when commenting on Blackstone’s classifications contained in his Commentaries on the Laws of England (1772) declared “...that acute distinction between *mala in se*, and *mala prohibita*, which being so shrewd and sounding so pretty and being in Latin, has no sort of an occasion to have any meaning to it; accordingly it has none”. The debate on whether or not there is any really difference between real and quasi crime, *mala in se* and *mala prohibita*, certainly predates the industrial revolution and seems to be no nearer a resolution. This would logically lead on to the view that any distinction between criminal and regulatory law, irrespective of how each is described, only exists in the minds of some of the legal profession, at least in the UK. The exceptions to the rules described previously in this Chapter are too extensive and numerous to allow for such a distinction to be made. Neither the penalties available or the enforcing agencies involved in prosecuting an offence are reliable tests and, as discussed above, strict liability offences can be criminal or regulatory, depending upon the circumstances. Is it any less moral to cause a death through dangerous driving, which would be considered a crime, or through

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803 Paul Almond, *Corporate Manslaughter and Regulatory Reform* (Palgrave Macmillan 2013) op. cit. n.503, p.122
804 Anon., *The Distinction Between Mala Prohibita and Mala In Se in Criminal Law* (1930) 30 Columbia Law Review 74 86
failing to provide a safe place of work, which would normally be considered regulatory?

It is clear that there is no objective test for distinguishing criminal from regulatory offences so why is a contravention of the health and safety legislation arising from unsafe conditions not considered “real” crime when its consequences could be catastrophic? The Law Commission acknowledged the problems of differentiating between regulatory and criminal law concluding that “...a rigid distinction between criminal or regulatory law and criminal or regulatory procedure may confuse rather more than it illuminates...”\(^{805}\) It goes on to identify three characteristics of a criminal offence; the case must be pursued through the Crown Court or magistrates’ courts, it must be proved beyond reasonable doubt to have occurred and if proved, the court may impose a “detrimental, punitive measure”. Most health and safety offences satisfy each of these characteristics and consequently would be described as criminal, even though the legislation they derive from is regulatory in nature.

### 6.7 Conclusion

The Corporate Manslaughter and Corporate Homicide Act 2007 was the Government’s response to the demand for companies to be ‘properly’ punished when they cause deaths through their activities and to address the particular difficulties associated with their prosecution as a consequence of their nature. It effectively criminalised what had previously been the domain of regulation with the implication that a regulatory approach to this particular aspect of unlawful activity was inadequate, inappropriate or had failed in some way. It is fair to say that the impact of the Act has been relatively insignificant in terms of the number of successful prosecutions and this will be discussed in more detail in the final chapter.

This Chapter set out to establish the difference between regulatory and criminal law in the context of workplace health and safety. As discussed, health and

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safety law is generally considered regulatory rather than criminal but the Corporate Manslaughter and Corporate Homicide Act 2007 sits uncomfortably between these two rather artificial categories seemingly neither one nor the other, or perhaps a bit of both. In practical terms, at least so far as deaths arising from work activities is concerned, it is of little consequence. There are similar levels of fines for offences under either the health and safety legislation (‘regulatory’) or the corporate manslaughter Act (‘true’ criminal legislation). There is, however, a far wider range of offences and penalties available under the health and safety legislation, including fines and imprisonment for individuals found guilty of an offence. In any case, they are not mutually exclusive and it is likely that many of the corporate manslaughter prosecutions will also have parallel health and safety prosecutions.

The first point to make is that, in general, there is no practical difference between criminal and regulatory law, at least so far as the consequences of a trial and subsequent punishment of offences is concerned, although attitudes to their enforcement may vary. The distinction between criminal and regulatory law is somewhat artificial, they are both criminal law in so far as the offences are prescribed in statute, although the term “true” or “real” crime is often used for the former, implying that, in some way, that there is crime that is not true or real.806 This leads on to the question of why some types of offence are viewed as a crime, whilst others are considered regulatory which leads to the further question of why regulation is viewed with “indifference” by the UK legal profession.807

Although a number of criteria have been discussed as the basis for differentiation between criminal and regulatory law, none of them are sufficiently robust to properly justify it and the conclusion must be drawn that the distinction is only to be found in some sections of the legal profession. In effect, there is no practical difference between what has been described as true or real crime, and regulation but it is inevitable that the debate will continue long into the future. It is still fair to say that true crime carries more stigma

806 Parker and others (eds), Regulating Law op. cit. n.758, p.144; Herring, Criminal Law op. cit. n.538, p.82.
807 Rowan-Robinson, Watchman and Barker, Crime and Regulation. A Study of the Enforcement of Regulatory Codes. op. cit. n.636
that regulatory crime although as more and more individuals are subject to imprisonment for health and safety offences, that perception may change in the future.

The final Chapter will now examine how this rather strange combination of what is perceived as true criminal legislation and the more traditional regulatory approach have impacted upon large organisations and corporations following the implementation of the Corporate Manslaughter and Corporate Homicide Act 2007 and how it will influence the future direction of corporate killing punishment.
7.0 General Conclusions

The history of prosecuting corporate killing in the United Kingdom is complicated, made even more so by a rather artificial distinction between regulation and true criminal law. This perceived distinction was discussed at some length in Chapter Six and whilst there may have been an actual distinction in mediaeval times between *crimina*, violations of royal peace, and *contraventions*, violations of administrative rules, that distinction has become increasingly blurred over the centuries to such an extent that, in practice, there is no practical difference between regulation and true crime. The penalties for each can include fines and/or imprisonment and they can both result in a criminal record. What remains is the question of stigma which some commentators suggest is greater for true crime rather than regulation. Stigma is not easy to measure but it is difficult to see how a prison sentence imposed for a contravention of a health and safety requirement results in any less stigma than a prison sentence imposed for any other type of criminal offence.

Having said that, there is no escaping the fact that health and safety legislation has evolved through regulation which is reflected in many of its characteristics, in particular the nature of some offences including the imposition of strict liability upon individuals and companies. There has been unease expressed by some commentators about some of the characteristics of health and safety offences but they have been tested in various courts and found to be lawful in their application. It must also be noted that they have proved effective in improving workplace health and safety in the United Kingdom and statistics would suggest it is generally better than in countries, where health and safety legislation does not exist or is poorly enforced. This would tend to support the view that employers will not invest in safety unless they are forced to do so through the threat of prosecution, fines and possible imprisonment.

Whilst the health and safety legislation developed in the UK over the last couple of centuries can be generally agreed to have been successful in improving health and safety in the workplace, it has been less effective in preventing the disasters that resulted in a major loss of life, but that was never the intention. There was an upwelling of opinion that the large companies involved in these
incidents had somehow escaped proper punishment, in effect they had got away with murder. The large fines imposed in some cases were not considered sufficient and there was a demand for “something to be done”. As discussed in Chapter Five, that “something” culminated in the Corporate Manslaughter and Corporate Homicide Act 2007 which was intended to punish organisations that caused the death of persons to whom they owed a duty of care. Very importantly, individual liability for corporate manslaughter was explicitly excluded from the Act but the offence of gross negligence manslaughter continued to be available where the death was at least partly attributed to the actions of an individual.

The failure to include individual liability for corporate manslaughter is one of the main criticisms levelled against the 2007 Act and that in itself is sufficient for it to be considered only a half-measure in dealing with corporate killing. Although the gross negligence manslaughter offence is available to prosecutors, it will only ever be able to be used where an individual senior manager can be shown to have day-to-day involvement in the operational activities of the organisation. This means that, inevitably, gross negligence manslaughter proceedings will only ever be able to be taken against senior managers in micro, small and the smaller medium-sized companies, senior managers of larger organisations will effectively be immune from such proceedings as a consequence of their separation from the day-to-day operational activities. This is obviously extremely unfair and results in a two tier justice system, but perhaps just as importantly, it means there is absolutely no individual manslaughter liability for senior managers in larger organisations. This, in turn, means there is little incentive provided by the 2007 Act for them to ensure safety at every level of the organisation for both workers and others who may be affected by work activities.

This is one area where the 2008 Act may give the health and safety legislation an advantage over the 2007 Act. As discussed in Chapter Three, Section 37 of the Health and Safety at Work etc. Act 1974 extends liability for an organisations’ offences to senior managers where it can be shown that they have occurred as a consequence of their consent, connivance, or negligence. Following the introduction of the Health and Safety (Offences) Act 2008, Section 37 offences
can now attract a prison sentence of up to twelve months and/or a fine of up to £20000 when tried summarily, or a prison sentence of up to two years and an unlimited fine when tried on indictment. Prison sentences have been imposed in respect of small number of Section 37 cases, but whilst it will never be easy to prove an offence, it does provide an alternative route to gross negligence manslaughter where senior managers of large organisations are implicated as a result of their consent, connivance or negligence in the death of a worker or other person. This in itself could make the ‘traditional’ health and safety approach more effective than the 2007 Act in the vast majority of cases.

Before finally concluding and for the sake of balance, any potential benefits of the 2007 Act must be identified and discussed. At least for a short period of time, it did raise and revitalise the safety debate in the UK and many organisations did review their approach to health and safety, including the requirements of the relevant statutory provisions. It must be recognised that it is quite a different matter for an organisation to be found guilty of corporate manslaughter rather than a health and safety offence, even though the circumstances and consequences may be identical. The bad publicity from a charge of corporate manslaughter should, for most organisations, be worrying enough, but to be found guilty and subject to a publicity order could cause serious concern for some. Unfortunately, the lack of proceedings for corporate manslaughter and, in particular, the complete absence of what could be considered high profile successful prosecutions since its implementation, has gradually reduced the impact of the 2007 Act and apart from that brief flurry of interest shortly before and after its introduction, it is now the subject of very few scholarly articles and commentary.

In conclusion, the Corporate Manslaughter and Corporate Homicide Act 2007 is not, in itself, a bad piece of legislation, it is more a question of its relevance. It has not had the impact that many had hoped for, which is partly attributable to the failure to include individual liability, but enforcement by the police is clearly a significant area of weakness since they have neither the resources nor expertise in the vast majority of circumstances that would give rise to corporate manslaughter proceedings. It is unlikely that corporate manslaughter will have a high priority in most police forces when many are stretched with anti-terrorism
activities and other violent crimes. It is impossible to know whether or not the Health and Safety Executive would have been more active in taking corporate manslaughter cases if it had been given the responsibility for enforcement but it is fair to make the assumption that they would, given their general track record for enforcement action.

The 2007 Act does not seem to have addressed the concerns of a two-tier approach to work-related deaths with the only successful prosecutions taken by the end of 2015 being against small or medium-sized companies although that has changed with the unsuccessful proceedings taken against Maidstone and Tunbridge Wells NHS Trust. It is likely that all of the successful prosecutions taken by the end of 2015 would have been equally successful as common law corporate manslaughter proceedings and this would seem to be supported by the number of corresponding gross negligence manslaughter charges brought against senior managers at the same time, indicating that the identification doctrine, had it still been required, would have been satisfied. At this point in time and taking into account the very small number of proceedings, it would appear that large organisations are still much less likely to be subject to prosecution for corporate manslaughter than small and medium companies. Similarly, the experience so far would indicate that gross negligence manslaughter charge will only be of concern for senior managers of the smaller organisations.

Following the demand for “something to be done” in light of Piper Alpha, Herald of Free Enterprise, Paddington, and other disasters, it can only be concluded that corporations had the best possible outcome they could have hoped for. The original inclusion of individual responsibility was deleted, the need to demonstrate a duty of care (according to the laws of negligence) and to show a gross breach of that duty of care caused by a substantial element of senior management failures, has resulted in very high barriers to be crossed and the larger the organisation, the higher those barriers become. It could certainly be argued that the eventual drafting of the Corporate Manslaughter and Corporate Homicide Act 2007 was perhaps more sympathetic to the arguments of corporations and other organisations than those seeking a more aggressive approach to punish them for deaths arising from their work activities. Until the
outcomes of proceedings against large organisations are known, the effectiveness of the 2007 Act will remain subject to speculation.

Without question, the 2007 Act is symbolic in so far as it was introduced as a consequence of public pressure to address a very specific form of unlawful killing. Whether or not it is, or will become, more than symbolic will only be properly judged when further proceedings, in particular against larger organisations, have been initiated but at this point in time it is looking increasingly unlikely that it will be anything other than the legislative equivalent of the emperor’s new clothes; no-one really believes in it but pretend that they do. The alternative to the 2007 Act would have been to address the identification doctrine directly and/or revise the health and safety legislation to include a specific offence of causing death through work activities. The Health and Safety (Offences) Act 2008 provided the courts with an appropriate range of penalties to deal with most circumstances including imprisonment for individuals held responsible, including through their neglect, for the deaths.

The original intention of this research was to examine the effect of the Corporate Manslaughter and Corporate Homicide Act 2007 on the behaviour of organisations (‘corporations’) in respect of deaths arising from their activities but it quickly became apparent that the real issue to address was why the 2007 Act was considered necessary in the first place. The completely unrelated Health and Safety (Offences) Act 2008 introduced a new dimension in health and safety regulation which must call into question the whole purpose of the 2007 Act. The history of health and safety regulation, the nature of corporations and corporate killing and, finally, criminalising what had previously been regulatory offences all have a part to play in the eventual, and rather confused, approach to corporate killing in the United Kingdom.

The Corporate Manslaughter and Corporate Homicide Act 2007 was the product of a campaign to punish corporations following a number of high profile accidents at the end of the twentieth and start of the twenty-first centuries. What all of these accidents had in common was a significant number of deaths and the failure of the State to successfully prosecute any of the large organisations responsible for corporate manslaughter even though that possibility had been previously established in law. It is worth noting that the
number of fatal and non-fatal accidents in the workplace had been reducing steadily over the decades prior to the 2007 Act with the introduction of the Health and Safety at Work etc. Act 1974 resulting in a dramatic decrease in the fatal accident rate which would indicate that the health and safety legislation was effective in its intentions. Health and safety legislation, and particularly the 1974 Act, was never intended to be punitive and nor was it intended to deal specifically with workplace deaths. Although it has proved effective in improving workplace safety, it is still perceived as something less than true criminal law and even though multi-million pound fines have been imposed for health and safety breaches, regulatory offences tend not to have the same stigma typically associated with criminal offences. The Health and Safety (Offences) Act 2008 which introduced prison sentences for a much wider range of offences may, in time, change some of the attitudes towards regulatory offences; a prison sentence will almost certainly carry the same social stigma irrespective of the nature of the crime.

The question, “Why were the high profile corporate manslaughter cases arising from work related fatal accidents in the latter half of the twentieth century and the early part of the twenty-first century unable to result in a successful prosecution?” is much easier to answer and was discussed at length in Chapter Five but in essence, the identification doctrine made it almost impossible for a successful manslaughter case to be brought against any but the very smallest organisations. This in itself created a two-tier system of justice with large organisations being immune from corporate manslaughter charges but small organisations being all too vulnerable to them. Similarly, managing directors of large organisations were also protected from gross negligence manslaughter charges as a consequence of their separation from the day to day operation of their organisations whereas it was much more likely that senior managers of small organisations could be directly associated with the circumstances leading to fatal accidents. Unfortunately this state of affairs seems not to have changed significantly following the introduction of the 2007 Act with mainly small and medium sized organisations being the focus for the new corporate manslaughter offence.
This leads on to the question “Will the Corporate Manslaughter and Corporate Homicide Act address the apparent or perceived shortcomings in the current approach to prosecution for corporate manslaughter following work related deaths?”, which is, perhaps, the most difficult to answer definitively. It has been in force for just over seven years and it is fair to say that it has not been tested in anger as yet. Apart from the novelty of the very first corporate manslaughter charge brought against R v Cotswold Geotechnical (Holdings) Ltd, subsequent cases could not be described as high profile and haven’t put the 2007 Act under public scrutiny. The failure to include individual liability in the Act will inevitably reduce its deterrent effect for large organisations and other than a flurry of interest when it was first introduced, the Act has faded into the background and there is not any evidence that organisations have modified their behaviour in response to it. It will almost certainly take a major tragedy similar to those generally considered responsible for the introduction of the 2007 Act before this question can be fully answered but on the evidence available to date, it must be in the negative, there is no indication that it will address those apparent or perceived shortcomings. If this the case, the penultimate question, “Is the Corporate Manslaughter and Corporate Homicide Act ‘symbolic’ rather than ‘instrumental’ and if so, is it an appropriate approach to dealing with workplace safety?” can only be answered yes, it is symbolic and no, it is not an appropriate approach to dealing with workplace safety.

With so few corporate manslaughter charges being brought in terms of the Act, and most of those against the smallest companies, it is difficult to see it as anything other than symbolic. That in itself might be sufficient for it to have the desired effect of modifying organisations’ behaviour to prevent the type of accidents seen in the late twentieth and early twenty-first centuries but there is little evidence of that happening. In many respects, the answer to this question is closely associated with the answer to the previous question, it will take an accident resulting in a major loss of life before the true nature of the Act is revealed. The importance of symbolism must not be overlooked, however. No matter how ineffective the 2007 Act proves to be, it has clearly established corporate manslaughter as a bona fide offence which any organisation held responsible for the death of a person could be charged with. Perhaps that in itself justifies the Act’s existence although Chapters Four and Five would
indicate that organisations of any size cannot be expected to behave in a socially responsible way unless there are punitive consequences for not doing so and high chance of being caught, so symbolism might not be enough.

The answer to the final research question, “With the introduction of the Health and Safety (Offences) Act 2008, has the “regulatory” approach finally been given the means necessary to properly address its previous perceived shortcomings and made the Corporate Manslaughter and Corporate Homicide Act irrelevant?” is no. If the purpose of the 2007 Act was to specifically address deaths arising from work activities, the 2008 Act is not in any way an alternative means to achieve that objective. The 2008 Act does not contain any new offences, its sole purpose is to provide for a wider range of penalties, including prison, for existing health and safety offences and contraventions. When combined with Sections 7 and 37 of the Health and Safety at Work etc. Act 1974, it allows prison sentences to be imposed upon individuals found guilty of an offence. Whilst it could be expected that prison sentences would be imposed where the outcome of an offence or contravention is death, the consequences of the contravention will only be one factor in sentencing although it might be an important one. In this respect it differs from the gross negligence manslaughter offence where the penalty is based on the consequences of the action leading to the fatality, the consequences are the offence. The 2008 Act had little impact on the financial penalties available for indictable health and safety offences, unlimited fines were already available as illustrated by the fine of £15 million imposed upon Transco.808

For all of its shortcomings, the Corporate Manslaughter and Corporate Homicide Act 2007 is here to stay. It is impossible to see into the future but given its track record over the past years, it is likely that it will continue to be of marginal significance with only a few cases being prosecuted each year. The number of prosecutions taken since its implementation is a very small percentage of the number of deaths arising from work activities over the same period of time and it is difficult to see any rationale for the cases actually taken. If the intention was to address the problems associated with punishing corporations whose actions resulted in the deaths of worker and others, an

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808 R. v Transco plc op. cit. n.339
amendment to the Health and Safety at Work etc. Act 1974 introducing a specific corporate killing offence might have been much more effective, particularly when combined with the Health and Safety (Offences) Act 2008, but that assumes a real commitment by the Establishment to punish corporations and other organisations that cause unnecessary deaths through their activities.
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Appendix A - Corporate Manslaughter and Corporate Homicide Prosecutions to December 2015

Cotswold Geotechnical Holdings Ltd - January 2010

Found guilty of corporate manslaughter and fined £385 000 following the death of an employee when the trench he was working in collapsed. This was the first successful corporate manslaughter prosecution.

The owner of the company, Mr Peter Eaton, was charged with gross negligence manslaughter but the charge was not pursued as a consequence of his ill-health.

JMW Farms - May 2012

Found guilty of corporate manslaughter and fined £187 500 plus costs of £13 000 (plus VAT of 20%) following the death of an employee when washing a large metal bin supported by a fork lift truck.

The victim jumped on the side of the bin which toppled, causing him to fall and it to land on top of him, causing his death. The lift truck was a replacement for the usual equipment which had been removed for servicing. The forks on the replacement lift truck were in a different position from the usual equipment and did not correspond to the sleeves on the bin, causing the bin to slip and fall on top of the victim.

The Recorder considered a fine of £250 000 appropriate for what was described as a foreseeable accident, but reduced it by 25% on account of a guilty plea.

Lion Steel Limited - July 2012

A complicated case, the charge of corporate manslaughter was laid against Lion Steel Limited following the death of an employee after falling through a fragile roof. The victim had no training, no risk assessment had been carried out and there was no safe system of work in place. In addition to the charge of corporate manslaughter, charges of gross negligence manslaughter were laid
against three of the four company directors and various health and safety charges were also laid, including breaches of Section 37 of the Health and Safety at Work etc. Act 1974 against each of the company directors.

The defendants successfully applied for the corporate manslaughter charges to be held separately from the individual charges against the company directors. The first trial was in respect of the individual charges but after a number of the charges were dismissed, an agreement was reached where the company pleaded guilty of corporate manslaughter in return for all charges against individuals being dismissed. The company was fined £480 000 with costs of £84 000.

**J Murray and Sons Limited - October 2013**

The charge of corporate manslaughter was brought against J Murray and Sons Limited following the death of an employee when operating a meal mixing machine. Although there were no witnesses to the accident, it is assumed he fell into the machinery when using it for its intended purpose. Safety panels had been removed to make it easier to add materials and were missing at the time of the accident.

The company pleaded guilty to the offence and was fined £100 000 plus £10 450 costs.

**Princes Sporting Club Limited - November 2013**

The Princes Sporting Club Limited pleaded guilty to corporate manslaughter following the death of an eleven year-old girl who died following a fall from a banana boat operated by the company. The company ceased trading shortly after the accident and was subsequently fined £34 579.69, the sum of the total assets of the company, plus £100 000 costs. A publicity order was also made, the first one ever, even though the company had ceased trading.

A charge in terms of Section 37 of the Health and Safety at Work etc. Act 1974 brought against the managing director of the company was later dropped.
Mobile Sweepers (Reading) Limited - December 2013

Mobile Sweepers (Reading) Limited was fined £8 000 following the death of an employee who was crushed to death when the hopper of a road sweeper he was working on fell on him. The company ceased trading shortly after the accident and had only £12 000 left in the bank at the time of the trial. The Judge also imposed a publicity order on the company.

In addition to the corporate manslaughter charge, the company director was charged with gross negligence manslaughter and in terms of Section 37 of the Health and Safety at Work etc. Act 1974. The gross negligence manslaughter was not pursued but the company director was found guilty in terms of Section 37 of the 1974 Act, fined £183 000 plus £8 000 costs and disqualified from holding the position of director for five years.

Cavendish Masonry Limited - May 2014

Following the death of a stonemason’s mate, crushed under a two-tonne stone lintel, Cavendish Masonry Limited was found guilty of corporate manslaughter and fined £87 117.69 with costs of £150 000. The company had pled not guilty to the corporate manslaughter charge having previously pled guilty to health and safety charges brought for the same accident.

PS & JE Ward Limited - June 2014

PS & JE Ward Limited was the first company to successfully defend itself against corporate manslaughter charges which were brought in respect of the death of a tractor driver who was fatally electrocuted when the trailer he was towing came into contact with overhead power lines.

Although found not guilty of corporate manslaughter, the company was found guilty of health and safety offences and fined £50 000 with £48 000 costs.

MNS Mining Limited - June 2014

Following the deaths of four miners when the mine they were working in flooded with 500 000 gallons of water, MNS Mining Limited was charged with four accounts of corporate manslaughter and the mine manager was charged with
four accounts of gross negligence manslaughter. Both the company and mine manager were found not guilty of the offences for which they were charged.

**Stereecycle (Rotherham) Limited - November 2014**

One worker was killed and another seriously injured when an autoclave used by Sterecycle (Rotherham) Limited to treat domestic waste exploded. The company, which went into liquidation shortly after the accident, was fined £500,000 after being found guilty of corporate manslaughter. At the time, that was the largest fine imposed for the offence and the first to be in line with that set by the Sentencing Guidelines Council.

Three employees were charged with offences in terms of Section 7 of the Health and Safety at Work etc. Act 1974, which were withdrawn, and one was also charged with perverting the course of justice but found not guilty.

**A Diamond and Son (Timber) Ltd - December 2014**

A family run timber merchants in Northern Ireland, A Diamond and Son were fined £75,000 with costs of £15,832 following the death of an employee who was crushed when carrying out maintenance on a large machine. Even though guards on the machine had been disabled and no training had been provided on repairing the machine in maintenance mode, the judge considered that the offence had arisen through human error rather than pursuit of profit. Other factors taken into account when setting the rather low fine was the debt of £1.4 million carried by the company at that time.

**Peter Mawson Limited - December 2014**

Following the death of an employee after falling through a fragile roof, the company pleaded guilty to corporate manslaughter and was fined £200,000 with costs of £31,500 and a publicity order was made. Both the company and the managing director, Peter Mawson, were also found guilty of health and safety offences with the former fined a further £20,000 and Mawson was sentenced to a prison sentence of eight months, suspended for two years and given a community service order of 200 hours unpaid work.
Pyranha Mouldings Limited - January 2015

Pyranha Mouldings Limited was charged with corporate manslaughter and various breaches of the Health and Safety at Work etc. Act 1974 following the death of a worker who was carrying out maintenance inside an oven used to create kayak moulds when it was turned on. The oven doors locked when it was switched on and there was no means of escape or alarm provided within it. The Company was convicted of the various offences and fined £200 000 with a share of the costs of £90 000.

The Company’s Technical Director was charged and found guilty of health and safety offences, sentenced to nine months imprisonment suspended for two years, fined £25 000 with a share of the costs referred to in the previous paragraph.

Kings Scaffolding Limited - April 2015

After pleading guilty, Kings Scaffolding Limited was fined £300 000 following the death of an employee who fell through a fragile skylight whilst carrying out roof repairs.

Huntley Mount Engineering Limited - July 2015

Four parties were found guilty of various offences arising from the death of a sixteen year-old apprentice when he was instructed to clean a moving part of machinery. The Company was fined £150 000 after pleading guilty to corporate manslaughter charges and the organisation that placed the victim with the Company, Lime People Training Solutions Limited, was found guilty of health and safety offences and fined £75 000 with £25 000 costs.

The Company owner and his son were also found guilty of health and safety offences, with the owner sentenced to eight months imprisonment and disqualified from being a company director for ten years and the son sentenced a prison sentence of four months, suspended for twelve months, 200 hours unpaid community service and a £3000 fine. Both father and son were subject to court costs of £15 000 each.
CAV Aerospace Limited - July 2015

CAC Aerospace Limited was fined a total of £1 000 000 with costs of £125 000 after being found guilty of corporate manslaughter and various health and safety offences following the death of an employee, crushed under a stack of sheet metal. The Company was fined £600 000 for the corporate manslaughter offence and £400 000 for the health and safety offences.

This case attracted additional attention because the fatality occurred in a subsidiary of the parent company but it was the latter that was charged and found guilty.

Linley Development Limited - September 2015

Following the death of a worker when a wall collapsed, Linley Development Limited was fined £200 000 plus £25 000 costs after pleading guilty to a charge of corporate manslaughter. A publicity order was made against the company.

The company director was found guilty of health and safety offences, given a six month prison sentence, suspended for twenty-four months, and fined £25 000 with £7 500 costs. The project manager was also found guilty of health and safety offences, given a six month prison sentence, suspended for twenty-four months, and ordered to pay costs of £5 000. Charges of gross negligence manslaughter against both the company director and project manager were withdrawn.

Baldwin Crane Hire Limited - December 2015

Baldwin Crane Hire Limited was found guilty of corporate manslaughter and various health and safety offences following the death of an employee when the mobile crane he was driving crashed after the braking system failed. Further investigation of the Company’s fleet found serious faults in the braking systems of a number of vehicles.

The Company was fined £700 000 plus £200 000 costs and required to post details of the offence on its website for a period of six months and place a similar notice in the trade publication.