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IN THIS ISSUE

CASTING A SAFETY-CULTURE SPELL

WHAT IF DEEPWATER HORIZON HAD HAPPENED IN THE UK?

RADIATION AWARENESS

FIRE RISK ASSESSMENT

Sacrificial flames

THE COSTS OF FAILING TO COMPLY WITH FIRE-SAFETY LAWS CAN BE MEASURED IN LOST LIVES, LIVELIHOODS, AND LOTS AND LOTS OF MONEY

Horizon scanning

The Deepwater Horizon disaster in the United States continues to make headlines around the world, with the reports focusing on the environmental consequences of the disaster rather than the loss of workers' lives. **Paul Verrico** and **Kevin Elliott** take a look at what would happen if there were a similar incident in the UK, and outline how pre-planning can alleviate some of the potential problems.

THE EXPLOSION ON THE DEEPWATER Horizon drilling rig on 20 April this year has already reportedly cost BP more than £20 billion and chief executive Tony Hayward his job. The focus of the news, however, has been on the catastrophic effect on marine and wildlife habitats, as well as the economic effect on local tourism and fisheries in America. Comparatively little coverage has been given to the fact that the blast resulted in the deaths of 11 platform workers and injuries to 17 others. Most media outlets refer to the Gulf of Mexico oil leak, rather than the largest work-related loss of life in the US since Texas city.[1]

But what if the incident had happened in UK waters? Of course, we have seen such a catastrophic incident here – the Piper Alpha oil-rig explosion in the North Sea, in which 167 people died, remains the world's worst offshore disaster in terms of loss of life – but that was 22 years ago, and legislation, procedures and expectations have all changed enormously since then.

Setting aside the offshore issues common to any incident on a drilling platform, which would be dealt with

Fire boats battle to control the blaze on the Deepwater Horizon oil rig in the Gulf of Mexico, which was caused by a leak and subsequent explosion in April this year © PA PHOTOS

under specific regulations, alongside the Health and Safety at Work, etc. Act 1974, the following points need to be considered.

Corporate issues

In the immediate aftermath of any tragedy of a similar scale to Deepwater Horizon, the organisation involved will be – as BP has been – under enormous public scrutiny. Every statement, action and response will be subject to media and expert analysis. An inconsiderate interview or a poorly-crafted gesture will do more harm than good – just ask the aforementioned Mr Hayward. The following are particularly pertinent:

1 *The families of the deceased*
Dealing sensitively and appropriately with the families of the deceased can often greatly assist the eventual outcome for any organisation. It is easy to miss simple issues that can have damaging consequences. We are currently acting on a case in which, inadvertently, the wrong family was told of a death, which caused untold unnecessary grief (two employees shared the same name). Hindsight identified the need for a more comprehensive records system to highlight the fact two employees shared the same name and care therefore needed to be taken to distinguish between the two.

It is very important to be aware that a normal, humane approach to families will not be seen as somehow admitting blame for what has happened. Families often face severe hardship in the immediate aftermath of an incident and, in many cases, an offer to pay travel and accommodation costs, lost wages and a contribution towards funeral expenses is usually appreciated. Indeed, failure to do so may well cause deep resentment from the family.

2 *Support for the deceased's colleagues*
The profound effect of a fatal accident on work colleagues (irrespective as to whether or not they witnessed the incident) should not be underestimated. Full support should be offered, such as interaction with line management and/or counselling.

Organisations must not appear faceless after such incidents. This is the time for visible leadership, best demonstrated through the on-site presence of a CEO or MD. We worked with an organisation that had lost a number of employees when the helicopter transporting them from an offshore installation crashed. The attendance of the CEO the very next day at the offshore HQ was, in deeply difficult circumstances, a much-appreciated gesture. Employees had lost colleagues, which was upsetting enough, but they were also apprehensive, as they still had to travel to the installations by helicopter in the future.

The physical presence of the CEO, who talked to some of the employees and explained what was going to be done to ensure their safety, was welcomed – far more so than an e-mail from corporate HQ.

3 *Clear lines of communication*
In the immediate aftermath of a fatal incident various parties will want information fast: employees; regulators; and the media. One person should therefore be designated to act as the single point of contact, and this person should be identified in the organisation's emergency plan.

Ideally, either this single point of contact, or another senior person should be nominated to deal with all press enquiries. We have all seen ill-equipped individuals go before the camera and give a damaging interview – again, the hapless Tony Hayward, who "wanted to get his life back" infuriated the residents of Louisiana.

Such mistakes can mean very capable individuals often come across in a very bad light, both for themselves and the organisation they represent. Some people are more able at dealing with the media than others, so identify who they are and give them the appropriate support and training before there is an incident.

Any causation theories, or extent of ultimate consequence theories, should also be carefully considered before a decision is made to go public. One of the problems for BP was its initial pronouncement that the impact of the explosion would be "very, very modest" – a claim which, in hindsight, was naïve in the extreme!

4 *The internal investigation*
You, as well as the regulator, will want to try to establish as soon as possible what has caused the accident, to ensure it will not be repeated. However, it is important to bear in mind, before the internal investigation is under way, that unless it is legally privileged, the resulting report will need to be disclosed to the regulators if properly requested, along with any witness statements taken by your internal employees. In essence, your own report could be used in evidence against you.

To avoid this, you should ensure before the investigation is underway that it is instructed by external lawyers, so that any reports or witness statements arising from the investigation are privileged, i.e. the regulators cannot compel their production.

It is worth bearing in mind that while the regulator will, in all probability, be able to obtain almost all pre-incident documents, it may also be able to obtain documents that post-date the incident. These documents will include e-mails, so it is crucial that organisations make it clear to all employees that e-mails speculating about the possible causes or consequences of an incident are unhelpful. If someone is not prepared to be cross-examined on the contents of the e-mail they intend to send, then they should not send it!

5 *Legal advice*
The stakes are high for both individuals and the organisations they represent (see below), with the worst-case outcomes being a prison term and/or a multi-million-pound fine. The time to find a specialist health and safety lawyer is not after any incident – you should have them sourced and available to contact 24/7 in any event. External lawyers will also be able to ensure the internal investigation is privileged (see above).

6 *Conflict of interest with employees*
Following any fatal accident the regulators will, in all probability, want to look at the roles of both the corporate body and individual employees. If any of the latter are suspected of having committed an offence they will probably need legal representation separate from that of the organisation. This may be funded by insurers (such as under a D & O liability policy), the organisation itself, or a trade union.

This separate representation point needs handling very carefully, as it can often come across to an individual

that the organisation is cutting them loose, which can be alienating. Care needs to be taken to ensure that the individual understands that it is in their best interests to be separately represented.

7 Time delay
Often, the most difficult aspect of managing a fatal accident is the time it takes for the process to be concluded. This will inevitably be measured in years, not months. The Potters Bar train crash occurred in May 2002, but the legal process behind it has not yet concluded. Organisations are experiencing ever more flux in their workforce and if it takes three years for a case to be concluded there is likely to have been at least one change of significant personnel since the incident. This makes it even more important that a thorough contemporaneous internal investigation is carried out.

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"We have all seen ill-equipped individuals go before the camera and give a damaging interview – like Tony Hayward and his comment about 'just wanting his life back'"

Legal process

1 Who investigates and what for?
Keeping matters as straightforward as possible, the Police will investigate for individual and corporate manslaughter, and the HSE or Local Authority (dependant on the activity being carried out) will investigate for health and safety offences.

The Police will have initial primacy for the investigation, if a fatality has occurred. If the CPS/DPP decides there is sufficient evidence for a manslaughter charge (individual or corporate) then that will be tried before any other substantive legal step. If they decide there is insufficient evidence for a manslaughter charge they will hand the investigation to the HSE/Local Authority.

2 Witness statements
When an incident is being investigated for manslaughter there is widespread confusion as to what powers the HSE can legally exercise. Of course, under the work-related death protocol, the HSE has a key role in advising the Police on any technical aspects of the manslaughter investigation. Can it, therefore, use its section 20 powers to compel witnesses to give answers in interview that could expose the employer, or a close colleague to a manslaughter charge? Indeed, can any evidence gathered using the section 20 process be admissible in subsequent proceedings for manslaughter?

In our opinion, the answer is no. Section 20 powers are specific to the HSE; the power to compel a statement is not available to the Police. The offence of manslaughter has a different standard of proof to an offence under the HSWA, and a conviction for manslaughter is perceived as more serious than a conviction for a HSWA offence.

The burdens of proof are different, too. Manslaughter requires a prosecutor to prove to the criminal standard under the usual principles of 'innocent until proven guilty' that the offence has been committed. By contrast, under the HSWA, the initial burden is on the company to prove that it has done everything reasonably practicable to safeguard the health, safety and welfare of those with whom it interacts.

For individuals considered for prosecution under section 37 HSWA, the facts of the offence committed by the body corporate must be established before the consent, connivance, or neglect of any senior persons can be considered. For those reasons, it is inappropriate for the HSE to exercise, or threaten the exercise of its section 20 powers in manslaughter investigations. It would be wrong in principle for the HSE to use powers specifically linked to the HSWA when the sanctions are so much greater for manslaughter. It would be a nonsense if, in effect, the Police could get around the constraints of the Police and Criminal Evidence Act (PACE) by the back-door use of section 20.

Of course, if the Police decide that there are no realistic grounds for conviction for manslaughter, the matter will be handed to the HSE/Local Authority to investigate health and safety offences. In that context, the use of powers by a HSE/Local Authority inspector under section 20 are entirely appropriate.

3 Inquests
The Coroners and Justice Act 2009 has, as one of its aims, the modernisation of the coronial system. Other past articles in this magazine[2] have detailed some of those reforms. Suffice to say for the purposes of this article that were a major disaster to occur and a manslaughter trial to be heard, it is unlikely that there will be

a need for an inquest, as the facts around the death will be examined in the trial.

By comparison, if the decision is made to hand primacy to the HSE, there will likely be an inquest before any health and safety prosecution is brought. However, we understand that this may be about to change, the inference being that the prosecution will occur first.

Very few companies are properly prepared for the emotional roller-coaster of an inquest, or public inquiry. The exchange between Robin Kellow and Gerald Corbett, the chief executive of Railtrack, at the Cullen inquiry following the Ladbroke Grove train disaster, highlights the very personal, intimate atmosphere such a forum can create: as Corbett sat to give evidence Mr Kellow took off a jumper to reveal a t-shirt bearing the words 'you killed my daughter'.

4 Public pressure

A chain of major events such as the sinking of the Herald of Free Enterprise, Piper Alpha, and the train crashes of the late 1990s demonstrated that the CPS may feel a strong public interest in prosecuting for corporate manslaughter in cases like Deepwater Horizon. With the wider 'senior manager' test under the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA) the CPS may legitimately also believe that it is more likely to pass the evidential test required to prosecute.

5 Fair trial

We recently acted for one of the parties in the Buncefield prosecutions. One of the issues related to finding members of a jury who could legitimately state that they could try the issues impartially and that they had not been personally affected by the blast. *The Times* recently called the leaders of BP 'global hate figures', against whom the public would take offence for almost any reason. Clearly, when a major incident occurs, the extent of headlines and editorial comment may make it difficult to have a fair trial when the matter is finally heard.

Prosecuting individuals and the company

We recently handled a case in which an employee was charged with manslaughter by the CPS and was in the court system within four months of the fatal accident at work occurring. The Crown Court judge who presided over the case then spent more than 12 months being hugely critical of the lack of joined-up investigation between the Police and the HSE, because it took another 13 months before health and safety charges were brought against our client, the employer. (As an aside, corporate manslaughter was never investigated by the Police, despite the matter occurring after the CMCHA's implementation.)

Our client was charged under section 3 of the HSWA and we were faced with the choice of either having to plead guilty to get credit but not being able to take part in the trial in which many of our client's staff would be called as witnesses, and in which evidence would be called that we would be unable to challenge; or, pleading not guilty but then effectively being the 'co-defendant' in a manslaughter trial.

Neither of these was an attractive proposition. Our application on joinder was refused, with the judge ruling that the manslaughter charge against the individual was inextricably linked to the health and safety charges against our client. We chose to plead. At trial, the individual was found not guilty of manslaughter but at the sentencing hearing, the judge had, of course, already heard the facts in far greater detail than in a normal plea and he stated he had heard lots of damning evidence against our client.

Individuals who are tried for manslaughter will almost always face health and safety charges as well. The Health and Safety (Offences) Act 2008 (HSOA) has redefined the landscape for such prosecutions. While no individual has yet been imprisoned using the increased powers of sentencing available under the HSOA, a major industrial disaster on the scale of Deepwater Horizon may well provide an ideal opportunity for the use of such powers.

There seems little doubt that had the powers under HSOA been available to Mr Justice Burnton when sentencing Gillian Beckingham following the death of seven people in Barrow after an outbreak of Legionnaires' disease,[3] he would have used them. His telling remark in passing sentence was: "Your failings were repeated and serious, which led to multiple deaths and very serious suffering."

For board members of a UK company who may reside outside the jurisdiction, there is also the real risk of extradition proceedings for any trial in the UK. The fear of standing trial in a UK court for an incident arising from a financial decision in a plush boardroom several years ago will not be pleasant, particularly when imprisonment may be an option if the case against the board member is proved.

Conclusion

Were a Deepwater Horizon-type disaster to occur in the UK, the chief focus of the authorities would be the actual or potential for loss of life, rather than the environmental disaster (as was the case in the recent Buncefield prosecutions). The potential sanctions for both corporate bodies and for individuals are far more powerful for safety offences causing loss of life than for environmental matters. No company expects to be the cause of such a disaster, but experience tells us that it is often very simple failures that lead to the most serious consequences.

In our opinion, the keys to managing a catastrophe of Deepwater Horizon proportions are to take a measured approach, demonstrate strong leadership, support both employees and the families of the bereaved, and not make rash media statements. No organisation that has caused a large loss of life is ever going to be popular in the immediate aftermath, but it may be able to point to an immediate appropriate response several years later when mitigating its failures. ■

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