

# The Corporate Manslaughter and Corporate Homicide Act 2007

towards **betteroutcomes** in NHS patient and occupational safety & health

Here you will find a summary of the Act of Parliament that came into force on 6<sup>th</sup> April 2008. Those who disregard the safety of patients, workers, visitors and others with fatal consequences, are more vulnerable to serious criminal charges: Corporate Manslaughter (in England, Wales and Northern Ireland) and Corporate Homicide (in Scotland).

Examples are given of some of the actions that NHS organisations can take, to protect themselves from unlimited fines, publicity orders, remedial orders. Taking these actions will also help you to reduce the risk of making career-limiting decisions.

## Background: multiple deaths, gross failures ..... no convictions

The lack of convictions resulting from these 276 deaths, contributed to the introduction of The Corporate Manslaughter and Corporate Homicide Act 2007:

- Herald of Free Enterprise (1987)      193 deaths  
The Sheen Report criticised the P&O attitude to safety, asserting that  
*'...from top to bottom the body corporate was infected with the disease of sloppiness....'*
- Kings Cross Fire (1987)                      31 deaths
- Southall train crash (1997)                      7 deaths
- Ladbroke Grove rail crash (1999)              31 deaths
- Hatfield rail crash (2000)                      4 deaths

## The Act applies to NHS organisations

It applies to all NHS organisations, Arms Length Bodies, Independent Healthcare organisations and a wide range of other organisations including partnership employers (trade unions and employers' associations), Government Departments and Police Forces.

## Gross failure resulting in the death of employees, patients and others

The Act sets out a new offence for convicting organisations where there was a **gross failure** in how activities were managed or organised. Organisations will be guilty of the new offence if the way in which their activities are managed or organised:

- cause death and
- amount to a gross breach of a **duty of care** owed to the deceased.

## **Gross failure?**

This will arise where the organisation's conduct falls **far below** what **could have been reasonably expected**. While 'far below' has yet to be defined in the Courts, Juries are likely to take into account, breaches of legislation and guidance:

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- HS(G)65: Successful Health and Safety Management

They will also take into the following into account: how serious and dangerous the failures were, the risk of death posed; admissible expert evidence; patient and occupational safety & health guidance relevant to the breach; those attitudes, policies and systems demonstrating the acceptable practices in the organisation that were likely to encourage a lack of compliance with the above.

## **Duty of care**

A duty of care exists for example, in respect to the systems of work and equipment used by employees, the condition of workplaces, other premises and in relation to products or services supplied to patients. The Corporate Manslaughter/Homicide offence is based on existing duties, already owed in the civil law of negligence.

## **The NHS and Corporate Manslaughter/Homicide?**

- 84,000 – the number of patient safety incidents reported to the National Patient Safety Agency, resulting in some degree of harm to NHS England inpatients in 2006/07
- 2,000 – The National Audit Office reported that 2,000 patient deaths a year are attributable to negligence. It is unclear if any of these deaths result from gross failure in the management and organisation of care and other activities

It has been suggested that had the following four events occurred after 6<sup>th</sup> April 2008, that the relevant NHS organisation could have been charged with Corporate Manslaughter:

- NHS Trust (a) - 90 patients died from Clostridium Difficile.
- NHS Trust (b) – 1 patient died from an air embolism
- NHS Trust (c) – 1 patient tore a ligament and was treated successfully, then contracted MRSA and died.
- Window Restrictors – between April 2002 and March 2004, seven people died following a fall from, or jumping from the windows of NHS buildings. The Window restrictors were missing in all seven cases.

## **A new approach**

Courts will look at management systems and practices across the organisation, with a view to finding an effective means of prosecuting the worst corporate failures in

managing patient and occupational safety & health. This introduction of this Act of Parliament, is an opportunity for employers to reconsider how risks are managed. Organisations are advised to ensure that they are taking proper steps to meet the legal duties referred to above in '**Gross failure**'.

### **The new test**

Juries will consider how the fatal activity was managed or organised, including the systems and processes for managing safety and how these were operated in practice. A substantial part of the failure within the organisation will have been at a **senior level**. Senior level refers to those who make significant decisions about the organisation or substantial parts of it. These include headquarters functions and operational management roles. Consultant Doctors and GP Practices (but not individual GPs) might also be considered senior level.

### **Investigation**

Prior to 6<sup>th</sup> April 2008, health & safety investigations were usually lead by the Health and Safety Executive. However, all Corporate Manslaughter investigations will be lead by the Police. While NHS benchmarking successes (including the Annual Health Check) are essential in today's NHS, it is unlikely that they will be relevant in the event of a Corporate Manslaughter investigation. For an overview of what will be relevant, check out '**Gross failure?**' above.

### **Penalties**

An organisation guilty of the offence will be liable to an **unlimited fine**. The Act provides for the Courts to impose a **publicity order**, requiring the organisation to publicise details of its conviction and fine. This will be commenced at a later date, when sentencing guidelines are available in autumn 2008. Courts may also require an organisation to take steps to address failures behind the death (a **remedial order**).

### **Can directors, senior managers or other individuals be prosecuted?**

Not under this Act - it is the organisation itself that will face prosecution. However, please note that since 1975, individuals can be prosecuted for gross negligence manslaughter/culpable homicide and for health and safety offences – under the Health and Safety at Work etc Act 1974.

Prosecutions against individuals will continue to be taken where there is sufficient evidence and it is in the public interest to do so.

As patient safety and occupational safety & health continue to move up the Corporate agenda, these prosecutions will probably be career-limiting too.

## **Can the offence be avoided by senior managers/clinicians delegating responsibility for health and safety?**

No. Failures by senior managers to successfully manage patient safety and occupational safety & health, will leave organisations vulnerable to charges of corporate manslaughter. Senior managers are advised to ensure that they and their organisation comply with current patient safety and occupational safety & health requirements. The Institute of Directors and the Health and Safety Commission has produced guidance entitled "Leading health and safety at work – Leadership Actions for Directors and Board Members" <http://www.hse.gov.uk/pubns/indg417.pdf>

## **What will happen in practice**

Employers have a legal duty (RIDDOR) to report certain incidents at work, including work-related deaths. Where a criminal offence is suspected, the police will lead the investigation and work in partnership with the Health and Safety Executive, local authorities and other regulatory authorities.

## **NHS Organisations can protect themselves and senior colleagues**

While the Government expects that cases of corporate manslaughter/homicide following deaths, will be rare, here are examples of questions that NHS Organisations might want to reconsider today, to ensure that their patient and occupational safety & health culture continues to perform well in the future, and under increased scrutiny. Objective and subjective evidence will be crucial.

Who is responsible, from the Board through to Specialities? Which individuals are in the 'senior level'? Do they understand their responsibilities? Are policies practical, audited and reviewed? Risk assessments are up-to-date? How do you notify staff of changes in policy? How are near-misses reviewed? Do you implement recommendations from SUI reviews, root cause analyses, investigations and Inquiries? Breaches, how does the organisation respond? Are minutes from these meetings actioned - Board and Committees, including Governance, Risk Management, Occupational Safety and Health, Patient Safety, Workforce, Clinical Effectiveness? Are emails and other correspondence reviewed? Are staff supervised effectively? 100% of staff are appraised regularly? How are underperforming staff managed? Are staff trained about policies and associated record-keeping?

### **Continuing Professional Development**

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### **About the Author**

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