

The Corporate Manslaughter and Corporate Homicide Act 2007: the impact for highway authorities

Introduction:

The Corporate Manslaughter and Corporate Homicide received royal assent on 26th July 2007 and came into force on 6th April 2008. After over ten years in the making, this is arguably the most significant piece of legislation relating to health and safety since the introduction of the Health and Safety at Work etc Act 1974. That being said, it has been considerably 'watered down' from the proposals originally submitted by the Law Commission in 1996 and subsequent Government Bills.

The intention of the new legislation is intended to overcome what has been recognised as a key defect in the common law of gross negligence manslaughter. Under this legislation, which has been around for decades, it was possible to convict organisations of manslaughter; however, in order to do so it was first necessary to establish that a sufficient senior manager was also personally culpable of manslaughter. In large organisations with many layers of management this proved impossible to do and so there was a failure to provide proper accountability for victims' deaths. It remains to be seen whether the new legislation will actually achieve what it sets out to do.

The Act is not intended to replace existing health & safety offences, and indeed the way in which what was the final Bill was drafted reflects this. It is anticipated that the number of prosecutions against organisations will increase by a relatively small number per annum, and it perhaps tempting to focus on this fact. HOWEVER, there is likely to be a significant shift in the focus on investigating work related deaths, and the impact that an in-depth investigation has on an organisation and individuals should not be underestimated.

Relevant extracts from the Offence:

'An organisation to which this section applies is guilty of an offence if the way in which any of its activities are managed or organised-

- (a) causes a person's death, and
- (b) amounts to a **gross breach** of a **relevant duty of care** owed by the organisation to the deceased.....

An organisation is guilty of an offence under this section only if **the way in which its activities are managed or organised by senior management** is a substantial element of the breach.....

A breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances;

“senior management” in relation to an organisation, means the **persons who play significant roles** in:

- i. **the making of decisions** about the whole **or substantial** part of its activities are to be managed or organised, or
- ii. **the actual managing or organising** of the whole or **a substantial** part of those activities.....

An organisation that is guilty of corporate manslaughter or corporate homicide is liable on conviction on indictment to a fine’

‘Relevant duty of care’

For highway authorities and their partners there are two main areas to consider in this respect; that of employer and service provider. The Act makes it clear that establishing whether or not a relevant duty of care exists is a matter of law, and so it will be solely down to the judge to make that decision based on the facts and he/she will then direct the jury accordingly.

In terms of ‘employer’ a duty of care will always exist to employees. An organisation has a duty to provide and maintain a safe place of work and equipment, to provide competent employees, and to establish and enforce a safe system of work. This duty may also be extended to encompass people who are not strictly employees but who provide services to an organisation (such as volunteers).

An organisation also has a duty of care under the Occupiers’ Liability Acts and so is responsible for keeping its land, buildings, land and moveable structures in a safe condition.

Having regard for the theme of this safety conference, the remaining part of this paper will be restricted to the role of the highway itself. HOWEVER, highway authorities and their partners should bear in mind the importance of issues such as occupational road risk, the safety of employees working on the highway etc., as the new legislation and new ‘driving’ offences will have a considerable impact should a fatality now occur.

In terms of ‘supplying services’, the issue of whether or not a duty of care exists for the purposes of the Act is far more complex and will have to be established through the courts over time. For example judges will have to grapple with the closely interlinked (but separate) issues of the primary duty to provide competent employees and a safe system of work (a potential relevant duty of care) as opposed to the vicarious liability an employer has in respect of employees’ negligence during the course of their employment (not a relevant duty of care).

With regard to highway authorities’ potential liabilities in the matter of a fatal road traffic collision (by that let us restrict the issues to that of the highway

infrastructure being a contributory factor) the relevant wording under Section 2 of the Act is that of duties owed in connection with construction and maintenance work. Section 2(7) of the Act states:

“(7) In this section-

‘construction or maintenance operations’ means operations of any of the following descriptions-

- (a) construction, installation, alteration, improvement, repair, maintenance, decoration, cleaning, demolition or dismantling of-
 - i. any building or structure,
 - ii. anything else that forms, or is to form, part of the land, or
 - iii. any plant, vehicle or other thing....”

Interestingly enough the Crown Prosecution’s initial guidance on the new legislation makes specific reference to this particular section and highway authorities. Their comment is *“note that simply because there is a statutory performance to perform an act, this does not create a relevant duty of care. Thus although a Highways Authority has a duty to maintain roads – s.41 Highways Act 1980 – the failure to do so does not give rise to a duty of care to a motorist in negligence. However a negligent repair would do so”*

However, Section 7(b) is not referred to in the CPS guidance, and yet it is the writer’s view that this may also be relevant in terms of activities such as safety inspections, since it states:

“(b) operations that form an integral part of, or are preparatory to, or are for rendering complete, operations within paragraph (a)”

Having said that, there would be all sorts of problems for the Prosecution in this respect, since in the matter of civil negligence under S41 of the Highways Act, in order for that duty to have been breached a claimant must be able to demonstrate that (a) the defect was dangerous and (b) it was caused by the failure to repair. The courts have continually avoided publishing guidance in the way of judgments, as to what constitutes a dangerous defect in law, and given the threshold for potential criminal liability is, quite rightly, a lot higher than that for culpability under civil law, it will be interesting to see their approach in this respect. It should also be noted that landmark cases such as *Gorringe v Calderdale Metropolitan Borough Council* [2004] and *Stovin v Wise* [1996] have significantly restricted highway authorities’ liabilities. Section 3 of the Act, which refers to ‘exclusively publicly functions’ will also be relevant for highway authorities when considering such landmark cases.

‘Gross Breach’

If a judge establishes that a duty of care exists it is then for the jury to determine whether or not that duty has been breached, and, if so, whether the breach is sufficient to constitute gross negligence. Any breach must fall FAR below what could reasonably be expected of an organisation AND the breach that caused death must be directly attributable to senior management failure.

Section 8 of the Act states that the jury MUST consider whether or not the organisation failed to comply with health and safety legislation. A breach of health and safety law in itself does not constitute gross negligence. The jury will also need to consider the severity of the breach(es) and the risk of death posed. This is potentially very dangerous waters for organisations as the line between a 'normal' health and safety offence and a manslaughter offence will not be an easy one to draw.

In determining the above the jury will also be invited to consider the attitudes, policies, systems and accepted practices relating to safety and the likelihood of these practices encouraging or tolerating failures to comply with health and safety legislation. It is likely that national Codes of Practice will be examined in this respect; for highway authorities examples of these are as follows:

- Framework for Highway Asset Management (April 2004)
- Well-lit Highways (November 2004)
- Well-maintained Highways (July 2005)
- Management of Highway Structures (September 2005)
- Best Practice Guidelines for Surfacing (June 2006)

Whilst such Codes are not legally binding, it is important for highway authorities to document where they have deviated from them and the reasons for doing so (i.e., to risk assess their policies having due consideration for national guidance). This is because the guidance itself will inform a jury with information on how a highway authority's duties have to be met and how this can be achieved. It will therefore also provide assistance in determining how serious a failing was.

One of the fundamental changes in the new legislation is the ability to aggregate collective senior management failures. This was not possible under pre-existing law and so the prospect of successfully proving a 'sufficient' failure on the part of at least one senior manager in a large organisation was impossible. However, to be able to aggregate a series of failures will assist the prosecution in demonstrating gross negligence.

It is also relevant to consider that whilst there are no individual offences contained within the new Act, the link between senior management, the decision making process and the managing or organising of 'safety' activities could expose individuals to gross negligence manslaughter charges (still unlikely for large organisations) or health and safety charges (far more likely). It is quite onerous to successfully defend health and safety charges; if a group of individual managers are individually in breach of health and safety offences at what point collectively does it cross the line of sufficient senior management failure?

'Senior Management'

The issue of what constitutes 'senior management' and 'substantial part' will be one of the key battle lines in the courts, and this will remain unclear until the first cases proceed to trial. The Act provides no guidance as to the

meaning of these terms, nor what factors the jury should consider in relation to this issue. For large organisations this will certainly be 'Board' level in terms of decision making, but it is also important to focus on the operational management of activities. For highway authorities it may be the case that heads of service groups, especially if considered collectively, are sufficiently senior.

However, this current uncertainty does not mean that those in a senior management position will avoid potential liability by distancing themselves from poor health and safety practices through delegation to more junior managers. Proper delegation to appropriately competent managers, and the provision of sufficient health and safety AND risk management resources at a 'lower' management level is quite acceptable, but senior management remain accountable overall. Organisations need to ensure that health and safety and risk management policies and procedures are properly complied with and scrutinised at senior management level. The root cause of incidents is almost inevitably management, organisational or planning failures, as the following demonstrates:

On 19th June 2001 Lord Cullen delivered a report in relation to the Ladbroke Rail disaster (1999) which was ground breaking for safety in all industries. He identified that there was a clear need to find the underlying cause of incidents and NOT just blame front line workers; his analysis showed that human error is, in the vast majority of cases, a consequence of organisational failure rather than the prime cause. This view is supported by the Health & Safety Executive (HSE):

'Accidents, ill health and incidents are seldom random events. They generally arise from failures of control and involve multiple contributory elements. The immediate cause may be a human or technical failure, but they usually arise from organisational failings which are the responsibility of management.....Organisations need to understand how human factors affect health and safety performance' [extract from HSG65].

The impact of the legislation on personnel who fall outside the 'senior management' remit

Whilst individuals at junior level would have to be personally virtually reckless with regards to safety matters in order to face prosecution for gross negligence manslaughter or health and safety offences, such officers should not be complacent.

The prospect of being involved in an in-depth police investigation, particularly for highway authorities, is very real and the impact that this alone has should not be underestimated. The effects are often far reaching and protracted for all concerned and no amount of legal counsel will mitigate this. The new legislation will undoubtedly place more pressure on the Crown Prosecution Service and enforcing agents to fully investigate work related deaths (and this includes fatal road traffic collisions) with a view to bringing charges.

When conducting an investigation the police start 'from the bottom and work their way up' in terms of the management chain. Staff at ALL levels will feel like they are being treated like criminals, and although ultimately junior staff at a relatively junior level may not ultimately be held culpable for failures that have occurred; to be in the position of being subjected to one or more 'murder type' interviews, or being obliged to give evidence that criticises colleagues can be extremely stressful.

Penalties on conviction

If an organisation is found guilty of the offence of Corporate Manslaughter, the following penalties can be imposed:

- An unlimited fine (almost certain)
- A remedial order, which means that the judge will order particular improvements to be implemented
- A publicity order, which means that the organisation will have to publicise details of the conviction etc.

In November 2007 the Sentencing Advisory Panel published a consultation document on proposed sentencing on the new offence. As far as fines are concerned, it is proposed that the starting point for an organisation convicted of Corporate Manslaughter (if a first time offender) should be 5% of its annual turnover, averaged over a three year period. This could be reduced if there are mitigating features (such as the organisation fully co-operating with the investigating authorities or a previously good safety record). However, it could also be increased to as much as 10% of the average annual turnover if there are aggravating features (such as more than one person killed, or other serious injuries occurring as well as death).

It should be noted that these fines are not insurable and will have to be met by the organisation itself. In the matter of local authorities it is likely that the courts will have due regard for the fact that any fine will have to be paid out of the public purse, and so any conviction will probably reflect this; albeit it will still be substantial when compared to health and safety fines.

However, it is obviously not just the financial impact of a conviction (and indeed to some degree a manslaughter investigation) that should be considered. The reputation of any organisation, whether it be a local authority or private sector, will be severely compromised and the successful recruitment and retention of staff will also be affected.

The Road Death Investigation Manual

For highway authorities there have also been other significant developments in terms of risk over the last few years; namely the publication and implementation of the ACPO Road Death Investigation Manual (RDIM). In addition to the 240 odd work-related deaths that occurred in 2006/07 (these are the fatalities reportable to the Health & Safety Executive under RIDDOR)

some 2,250 fatal road traffic collisions occurred in the UK. It should be noted that deaths on the road, irrespective of whether they occur 'at work', are generally not reportable under RIDDOR. For the purposes of this paper, again it seems relevant to focus on the role of the highway infrastructure.

Every year nearly 3,500 people are killed on the UK's roads, which equates to almost four times those who are victims of homicide. Even though some 1,000 of these deaths occur 'at work' they are not reportable to the HSE under RIDDOR. Notwithstanding this, the Police Service has a duty to conduct a thorough investigation to establish the circumstances that have led to a road death and to discharge its responsibilities to HM Coroner. Article 13 of the European Convention on Human Rights (ECHR) also places responsibility on the police that 'when an individual dies in suspicious circumstances' they should conduct a 'thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the relatives to the investigatory procedure'. [Kurt v Turkey (1999)].

All investigations are commenced on the premise that the death is an unlawful killing until proved otherwise.

In 2001 the Road Death Investigation Manual (RDIM) was published in response to a recognised need to standardise the way in which fatal and serious road traffic collisions were investigated. The RDIM is essentially a national code of practice for police forces and over the last six years it has been adopted throughout the UK. Not only has the RDIM substantially changed the police's attitude and approach to road death investigation; it has also had a significant influence on the entire judicial system from HM Coroners, the Crown Prosecution Service through to the criminal and civil courts. The RDIM has introduced a whole new area of risk to highway authorities and their partners and it is essential for them to adapt to these changes.

In the writer's view, it is important, however, to appreciate the intent of the road death investigation process. Many highway authorities appear to focus entirely on the potential criminality issues and so important opportunities are missed in terms of casualty reduction and risk management measure.

It is a matter of fact that people, or organisations, which commit criminal acts, will be punished accordingly and it is, of course, of paramount importance to protect potential liabilities and reputation, but for highway authorities these are few and far between. The new legislation does not, in the writer's view, greatly increase the risk for highway authorities in terms of being charged in relation to third party fatal road traffic collisions.

There appears to be a common misconception that because it is the police who investigate road deaths, it is a criminal investigation from the start. This is NOT the case. It is true that the police use the same criminal model (RDIM) to investigate fatal and potentially fatal collisions so that their investigations aspire to be consistent, robust and transparent. HOWEVER, first and foremost the police work for the victims' families and HM Coroners when

investigating road deaths. Every road death is initially a fact finding mission and criminality is a separate issue, albeit interlinked. If there is evidence that potential criminal acts may have been committed then the police invoke their statutory instruments and pursue a criminal investigation.

The role of HM Coroner

It is HM Coroner's responsibility to deliver a verdict in relation to the cause of death. The only time an Inquest will not be held is when sufficiently 'serious' criminal charges are pursued, such as corporate manslaughter or the offence of causing death by dangerous driving. In such circumstances the inquiry will proceed straight to the Crown Court.

Inquests themselves are not about apportioning blame, although in reality they can develop into 'mini trials' because of the adversarial nature of legal representatives and the fact that they will have in mind the need to protect organisations against potential HSE offences and civil claims. It is for HM Coroner to manage the disclosure of evidence in this process and to ensure that there is sufficient information to determine a cause of death, and the circumstances that led to the death itself. There are three verdicts that can be delivered:

- Accidental Death
- Open Verdict
- Unlawful Killing

If upon receipt of the police investigation file (pre-Inquest) the Coroner determines that the latter two verdicts may be relevant, it is more than likely that the jury will be called to listen to the evidence and decide on the verdict. HM Coroner will, in these circumstances, act as a pseudo judge. HM Coroner also has the powers to direct the police and CPS to conduct a more thorough investigation if felt necessary.

Any information collated by the police prior to disclosure at Inquest is sub-judice (not in the public domain) and they are under no obligation to disclose it prior to the Inquest. This can cause difficulties for highway authorities and their partners where the highway is considered a potential contributory factor. It is, in the writer's view, and indeed experience, essential to establish a good working relationship with the police officers who are responsible for investigating fatal road traffic collisions. Much of the traditional barriers can be overcome by co-operation and appreciation of the RDIM process.

How police investigate fatal road traffic collisions

Most collisions have multiple causative factors and the police examine all the possible contributory ('what went wrong') and precipitating ('why it went wrong') issues during their investigation of a road death. In simplistic terms the police 'reconstruct the collision' and primarily focus on:

- The condition of the vehicle

- The road and traffic environment
- The behaviour of road users

Evidence in these areas (physical, witness and documentary) is used in making an assessment as to causation and contributory factors. These are reported to the Crown Prosecution Service and, in the event of a fatality, the Coroner's Court.

As the breadth and depth of investigations has increased since the introduction of the RDIM, it was inevitable that the highways infrastructure would attract greater scrutiny. Indeed the second version of the manual published in 2004 (Version 3 was published in December 2007 but is less prescriptive; however the superficial mention of the role of the highway should arguably be taken at face value) introduced specific guidance in relation to the road and the role of highway authorities, as the following extract shows:

'The layout of a road, its associated facilities and features and its state of maintenance/repair can all be contributory to the occurrence and severity of a road traffic collision..... The performance of a highway authority responsible for the road where a collision has taken place is a vital consideration during such investigations..... When a collision has occurred and the highway involvement is alleged then the highway authority should be able to show that it took reasonable measures to ensure that the safety of the road user was not compromised. It should be noted that when determining whether reasonable measures have been effected on any particular road, it is necessary to consider the character of the road and the nature of the traffic using it, i.e not all roads are required to be maintained to the same standard. The prior knowledge held by the highway authority on a road is also of great significance, e.g. its collision record, whether any complaints had been received from the public or local councils, and when inspections and surveys from the road have been undertaken and their findings.

An in-depth investigation into the performance of a highway authority will typically seek answers to the following key questions:

- *Were the policies, procedures and practices developed by the highway authority reasonable and well considered, when taking into account statutory duties, powers, and national and local best practice?*
- *Were the policies, procedures and practices developed by the highway authority consistently implemented?*
- *Did the highway authority act reasonably in response to all of the pertinent information it had available?'*

In practical terms, in order to satisfy the above requirements, the highway infrastructure is automatically considered, and it is the writer's view that the latest version of the RDIM will not alter the police's focus. Where an

investigation raises highway related issues of causation they predominantly fall into two categories; maintenance and design. The following are examples (these are not definitive lists) of areas considered:

- Defects in the wearing course (potholes, fattening up, raised or sunken ironwork etc.)
- Road surface condition (friction levels, is there evidence that the surface has been contaminated pre-collision that might have led or contributed to loss of control?)
- Rutting or channelling
- Missing, obscured, worn or incorrect road markings and signs
- Missing or defective street lighting
- Roadside protection – have safety fencing, central reserve barriers and crash cushions been properly maintained?
- Standing water – is the highway drainage system sufficient and has it been properly maintained?
- Ice – are sufficient winter maintenance procedures in place?
- If roadworks are in situ, are they adequately signed and guarded to protect the road user (both drivers and pedestrians)?
- Have verges, hedgerows etc been properly maintained to ensure that sight lines are adequate?
- Evidence of prior collisions (site pathology; debris from other vehicles, strike marks on kerbs, tyre marks on the road surface etc.)

Generally, in the matter of road death investigations, highway authorities and police forces do not work particularly closely together. Highway authorities tend to be very defensive and police forces are not very forthcoming with information; there is an element of mistrust, and much of this is borne from a lack of understanding and communication between both parties. Much of the angst can be removed by both parties having an understanding and appreciation of each others roles, and indeed the road death investigation can be used in a positive way to assist in achieving casualty reduction.

Stage 1 of the road death investigation process: establishing the facts

If the highway infrastructure is considered to be a possible contributory factor to the collision then the police will seek information from the highway authority and/or its agents. Initially the information required is likely to be relatively 'low level' and restricted to records, and mainly relevant to the collision site itself. For example, if there are defects in the wearing course the police would require sight of the following information (this is not an exhaustive list):

- A copy of the safety inspection policy and any accompanying procedural documents
- Details of the safety inspection frequency for the road in question
- A copy of the pre-collision safety inspection records (the period will vary, but initially the police may only require the last inspection record or a year's worth of records)

- Details of any other surveys that may have been undertaken by the highway authority in a relevant period (specified by the police), such as SCRIM or SCANNER
- Details of any maintenance (planned or reactive) undertaken or planned for the road
- Details of any complaints (including claims) or other known collisions/incidents during a relevant period (specified by the police) and the highway authority's subsequent action

Although the police have the power to secure evidence from the start of the investigation by way of a search warrant, in practice this rarely occurs. They do not wish to unnecessarily disrupt the day to day operation of delivering a highway service and as long as authorities are seen to co-operate in a reasonable manner then this information is obtained without the need for more 'drastic' measures.

It is essential that highway authorities are able to produce a complete set of records to satisfy the police and HM Coroners. It should be appreciated that the police will examine their own databases for records of incidents and they will also be obtaining information from witnesses (or other members of the public who contact the police because they feel that they have information that may be relevant to the collision). If the highway authority is unable to produce satisfactory records to demonstrate that it has taken reasonable steps to safeguard the highway user and so discharged its statutory duties, OR there is conflicting information between their records and evidence obtained from other sources then matters may escalate.

What an in-depth road death investigation entails

If information is unavailable from a documentation point of view then the police will be obliged to try and clarify the facts via relevant personnel. It is not automatically the case that personnel will be interviewed under caution; depending on the level of information required and the amount of co-operation that the highway authority has provided, the police may submit a request for personnel such as highway inspectors or engineers to provide a witness statement. This is a voluntary process and personnel are able to have legal representation, although it is the individuals themselves who will be obliged to respond to questions posed by a police officer (or in some cases a civilian officer) so that a written statement can be produced. It will also be for the individuals to sign the statement and to verify that any information they have provided is true to the best of their knowledge. It is also quite possible that they will be obliged to attend the eventual inquest and answer questions that may be posed by HM Coroner or relatives of the deceased.

Although the above process is voluntary it can still be a daunting process for individuals and it is likely that they will feel very vulnerable. They will not be privy to all the information that the police have collated from other parties and, to an extent, activities such as safety inspections are relatively subjective. Individuals may find it difficult to justify decisions (especially in the matter of taking no action) made prior to a fatal collision if there is no contemporaneous

evidence available. The police, HM Coroner and indeed the victims' families will expect highway inspectors and engineers to be able to demonstrate that they made professional decisions made on sound rationale; if this process is not auditable via documentary evidence then it can be a very difficult hurdle to overcome in terms of preventing an in-depth investigation.

No manslaughter charges have ever been brought against a highway authority but several in-depth investigations have been, or are in the process, of being undertaken by police forces. HM Coroners are placing much more emphasis than perhaps previously on the role of the highway and fatal collisions can attract a huge amount of media and public interest.

If there is an indication that potential criminal offences may have been committed, or police forces consider that highway authorities have not properly co-operated in providing information, then the emphasis of the investigation will escalate.

The police are not experts in highway, manslaughter and health and safety legislation because that is not their responsibility. As such, although they will employ relevant specialists to assist them in collating evidence, the highway authority will be subjected to close scrutiny and the investigation can mushroom beyond the fatal collision itself. For example, if there is evidence that records have been 'doctored' or deleted (and the police do have the means of establishing this) then there are other criminal charges that could be brought against individuals and the organisation (e.g., fraud). The police will be looking for any evidence of systemic failures and the investigation could encapsulate the rest of the organisation, rather than just being restricted to the highway element.

The damage to individuals and organisations, just from an investigation, can be substantial. There will be very limited feedback from the police and the investigation will be lengthy. It WILL affect individuals' professional AND private life. Examples of some of the ramifications are as follows:

- Raids (not necessarily during sociable hours) to seize computers, policy and procedure manuals, files, emails – this relates to homes as well as offices. The police may empty offices and then return irrelevant information at their own convenience
- Removal of laptops and mobile phones/PDAs/Blackberrys. They WILL download mobile phone messages and emails, including those items people thought they had deleted
- 'Cloning' of all computer servers
- During the seizing of evidence the police have the right to retain personnel (irrespective of whether or not they are potentially part of the investigation) on the premises until ALL the evidence has been secured, or they have the right to remove all personnel from the premises (which is now a crime scene) until the evidence has been secured

Once the police have had the opportunity to examine all of the evidence seized they have a number of options:

- They are satisfied that the investigation can be concluded (extremely unlikely at this stage) and the case referred to the CPS/HM Coroner
- They need to interview individuals, both potential suspects and witnesses, to secure further evidence (almost certain)
- There is evidence of potential fraud or other serious criminal offences, in which case the matter should be referred to the police's Major Crime Investigation Unit

Issues to consider

If there is no leadership from senior management in relation to risk management or health and safety management then there cannot be any direction or motivation in this aspect. Thus any policies or procedures relating to safety are rendered ineffective. The true core of the new legislation, in the writer's view, is the actual culture towards safety, whether it is towards employees or members of the public. It is not about making mistakes; it is about instilling the importance of having realistic policies and procedures which focus on safety above all else, and ensuring that steps are in place to monitor the effectiveness of these policies and procedures. If there are gaps, or mistakes that occur, then senior management should be proactive and ensure that lessons are learned and any appropriate control measures implemented.

In the matter of local authorities it is accepted that there are finite resources; this is not the issue. How these finite resources are spent is, however. For example, when considering the role of the highway infrastructure let us look at repairing defects or undertaking crash remedial measures at collision cluster sites. As long as there are robust procedures in place for risk assessing sites and prioritising funds appropriately, and these procedures can be evidenced by way of an audit trail, then highway authorities and their partners should have nothing to fear from the new legislation or the road death investigation process. However, if authorities do not comply with their policies, or override them due to local pressures, then this may alter matters.

- It is imperative that authorities and their partners have complete audit trails in place to demonstrate that they have complied with their policies and procedures, or, where appropriate, to evidence where they have made a conscious and reasoned decision to deviate from them.
- Managers and individuals should ensure that they have sufficient equipment to undertake their duties (both in terms of their own and the public's safety).

- Managers and individuals should ensure that they maintain (and retain) sufficiently detailed records detailing their day to day decision making processes so that in the event of an investigation they are able to justify their actions or inactions. Lack of audit trails can be misinterpreted by the police as 'what are you hiding?' and with hindsight failures can often appear worse than they actually were.
- Managers and individuals should ensure that their job descriptions accurately reflect their role and responsibility within the organisation.
- Managers and individuals should ensure that their employer has sufficient insurance cover. Organisations need to check their Employers' Liability and Public Liability insurance policies to determine whether or not police and HSE investigations are covered, as well as proceedings in the crown court for both health and safety AND manslaughter offences. Some policies just cover health and safety prosecutions in the magistrates' court.

Issues to consider when a fatal incident occurs

DO NOT rely on the police and other enforcing bodies to establish failures; it is paramount to undertake timely in-house investigations into fatal incidents, and for highway authorities these should not just be restricted to employees. There may be concerns about civil or criminal proceedings following a fatal incident, which may result in an organisation believe that it is better not to investigate, but failings cannot be rectified if it is not known what went wrong. Furthermore the fact that an organisation has been proactive and thoroughly investigated an incident AND, in the event of systemic failures being identified, undertakes/plans remedial measures to prevent similar futures occurring is clear evidence that it has a positive attitude towards health and safety.

Organisations can of course choose to instruct lawyers from the very beginning to deal with any requests for information submitted by the police. Similarly the police can invoke their considerable statutory powers to obtain evidence from the very start of an investigation. Generally, highway authorities and police forces do not work particularly closely together at anything other than a strategic level because of perceived barriers between the two organisations. Certainly in the matter of road death investigations, highway authorities are naturally very defensive and police forces are not very forthcoming with information; there is an element of mistrust, and a lot of this is borne from a lack of understanding and communication between both parties. It can also provoke in-depth police investigations. Kent has proved that it is possible to establish a formal joint agreement of co-operation that allows a lot of the angst associated with the RDI process to be removed.

In 2005 Kent Police and Kent Highway Services established a joint protocol for exchanging information in relation to fatal and potentially fatal road traffic collisions and other highway related safety issues. In essence this protocol deals with Stage 1 of each road death investigation to negate the need for

search warrants etc. Under the terms of the current protocol KHS has a single 'source of truth' to deal with the in-house investigation and provide information to Kent Police's Serious Collision Investigation Unit. The source of truth is not an engineer or solicitor, but a risk manager. It is important to understand both the road death investigation process and highway legislation, and to be removed from operational issues in order to ensure the investigation is robust and objective. The protocol has proved extremely beneficial for both parties and has removed much of the angst that can be associated with this area of work. The protocol is not designed to deal with a criminal investigation (i.e. Stage 2), BUT if that situation were to arise the intention is that it would sustain the day to day activities (and indeed working relationship) between both parties.

If it is not possible to establish such an arrangement that KHS has then it is important for authorities to conduct their own in-house investigations. These investigations should be as objective as possible and conducted by competent personnel (the team should be small so as to ensure consistency in approach). It is also important to co-operate with the investigators as much as possible; this can be an important mitigating factor.

The author:

Ros Baldock is the Risk Manager for Kent Highway Services and instigated the joint protocol with Kent Police's Serious Collision Investigation Unit (SCIU) in 2005. Ros is the 'single source of truth' and has established an extremely successful working relationship with SCIU, which comprises some 30 officers. KHS has to deal with some 85 fatal and 35 potentially fatal road traffic collisions that occur on its highway network each year. The protocol has led to true partnership working between KHS and Kent Police in terms of road death investigations, and the benefit of this arrangement is also recognised by HM Coroners in Kent.

Enquiries or expressions of interest in terms of networking are welcomed and can be sent to ros.baldock@kent.gov.uk.