When the wheel falls off

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ABSTRACT

Police investigations into organisations following a road death can be a disruptive process. Prior understanding of the investigation process, and what the Police are looking for, can help an organisation to reflect on the suitability of the organisation's existing policies and procedures by ensuring they are suitable and sufficient. Such a process can assist in establishing gaps between policy and real world application. Importantly however, the proactive process can lead to the development of safer working environments.

1. INTRODUCTION

The EC and UK political 2010 year targets include a commendable and progressive stand to reduce those being killed and seriously injured on our roads by 40%, and this figure rises to 50% for child casualties [1]. In the UK our rates of fatal collisions have however remained largely static for a few years, killing some 3,000 [2] annually at a financial burden to society in the region of £4.2b. After some seven years in the discussion stage the introduction of the long anticipated Corporate Manslaughter legislation became law in April 2008. With the current focus on the reduction of fatal road traffic incidents how will this legislation potentially impact on your business and liability as a senior manager? Is there anything you should be considering now that may make a difference to your potential for corporate liability? This presentation is not intended to cover the detail of the legal aspects of the legislation; however it will offer an insight into what you could expect from a Police investigation that is aimed at providing evidence for consideration for potential liability.

2. CRIMINAL INVESTIGATION

One of the first triggers to an investigation could be a call to the corporate office informing you that one of your employees has just been involved in a fatal incident. But it may not involve an employee and the visit from the Police may not necessarily be immediate. For example, you may have had a duty of care for others due to the nature of your business, the services you provide or the something you have constructed or are responsible for maintaining. Such a call to your office may be completely unexpected and depending on the circumstances the Police may call with a warrant to inspect and seize company records.

Such an investigation is likely to be a very uncomfortable and intrusive experience, no matter how polite the officers are. How well would your company currently stand scrutiny of the searching process if it were to happen today? You may have a collection of company policies filed away somewhere, you may have even created risk assessments, but how does your policy actually relate to the reality of day to day operational practice?

Relying on the belief that you had a policy and that you once told someone to comply with the policy is likely to prove insufficient.

The Police follow guidance from the Road Death Investigation Manual, [3] which defines the investigation structure. Leading the investigation will be a senior investigating officer who is responsible for the policy, direction and the depth of the investigation process. This is the officer that could, by the nature of the scope he sets for the investigation, make normal working life very uncomfortable. This is not as a result of a vindictive desire to cause disruption to the organisation but as a consequence of what he is likely to find, or in many cases, may not find. The senior investigating officer could be likened to the conductor of an orchestra, conducting a team of specialist investigators. He is responsible and accountable for creating policy for the investigation. From policy, lines of enquiry are developed and actions created for each element of the line of enquiry. For example this could be locating all potential witnesses, or more significantly, the policy to investigate a particular organisation.

In their basic form a collision investigations will comprise of three elements:

- Road user
- Vehicle
- Environment

The understanding of each of these elements, as appropriate to the prevailing circumstances, will draw together a holistic perceptive of the event from which learning can be made and from which liability, where appropriate, can be established.

By setting a policy to investigate your organisation the Police are attempting to establish why certain actions were taken, why they may not have been taken and comparing them against statutory obligations or industry practice. They will be looking into the procedures of the organisation and whether they may have led or contributed to the incident. In addition, they will look at the extent to which the circumstances of the incident extend into the organisation; is it an unforeseen isolated incident, or one where prudent care has failed to be exercised.

It must be remembered that incidents will occur; the greater the size of your vehicle fleet or the scale of your highways maintenance contracts, the greater the potential is for exposure to risk. The chance of being subject to an investigation therefore increases, however, this does not imply liability. Liability will largely be considered on the practices and procedures adopted and whether in the circumstances they were reasonable and sufficient.

The Police may adopt a two level strategy to their investigation, working both on a top down and bottom up approach at the same time. The benefit of this as an investigative approach is that it provides an early indication and gap analysis between what is supposed to happen whilst at the same time establishing what did happen. It is likely to involve interviews with senior management and at the same time interviewing the various roles of operations and those involved in the incident, whether directly or indirectly. Depending on the circumstances it is possible that a joint investigation will be undertaken with the Health and Safety Executive (HSE) where agreements and protocols have been established [4], [5].

3. BURDEN OF PROOF

Having gathered the information, the Police will compile a case file and will present their findings to the Crown Prosecution Service (CPS) for their decision on criminal liability and whether to prosecute or to take no action. The decision not to prosecute under Corporate Manslaughter legislation may not necessarily exclude action being taken by the HSE for other breaches of Health and Safety legislation.

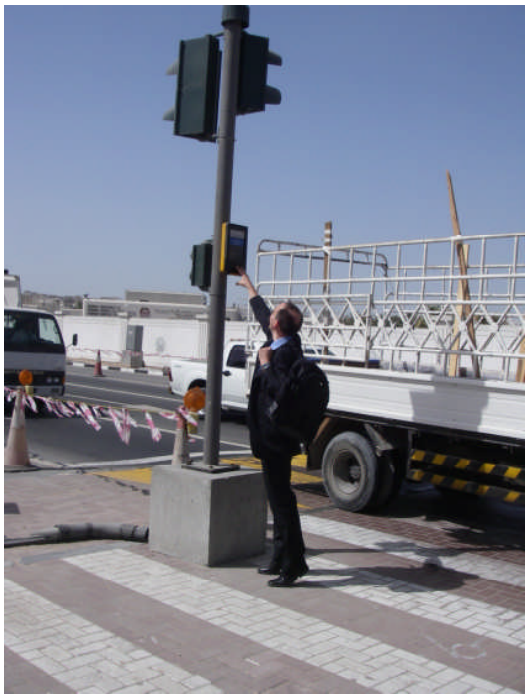
Generally for criminal proceedings, the burden of proof required to be established is beyond reasonable doubt, a very high level of proof on which the onus to establish is placed on the CPS. In cases involving Health and Safety legislation there is a slight variation on this onus which was created by Section 40, Health and Safety at Work Act 1974. This section states that a failure to comply with a duty or requirement to do something so far as is practicable or so far as is reasonably practicable, or to use the best means to do something, it shall be for the accused to prove (as the case may be) 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 to satisfy the duty or requirement. In such cases where there is a change of the onus of responsibility to the defendant, the burden of proof that is required is lower and is based on the balance of probability.

When the criminal investigation is complete the civil liabilities may be considered by those that have suffered loss. In such cases it is likely that the evidence gathered for the potential criminal investigation can be reused, however on this occasion the burden of proof that is required to be established is the lower balance of probability.

4. ENSURING SAFER PROCEDURES

There can often be a considerable difference between what is considered as company policy and the reality of operational practice. Conducting internal audits and reviewing suitability of policies and procedures is essential. Documenting the process and the intervention measures taken is likely to assist in establishing a safer working environment but also reducing the risk of corporate liability. When reviewing procedures it is recommended that consideration is given to documenting the policy decisions and the rationale on which they were based. Often in hindsight some decisions can appear ill-founded when additional information, perhaps not known at the time, is considered. If the decision and rationale is recorded it shows the thinking and procedures that were being considered. Something which is slightly harder to consider is to document a negative decision. For example, when the organisation has considered various options why the body decided not to adopt a particular action. Having a policy is a helpful start; however it is essential that the policy is communicated and that the effectiveness of the implementation and compliance is established and constantly subject to review to ensure it remains sufficient and suitable.

5. WE ALREADY DO THAT



Perhaps the largest single learning measure that can be placed on any organisation is to guard against the perception; *'We already do that.'* It is often a defence mechanism as a response in the belief that what is being suggested is common sense. The following examples of real road systems can be seen where there is an obvious failure of common sense. In the first photograph, the pedestrian crossing control box has been placed at a height that only the tallest of pedestrians could reach, because the original pole has been mounted on a concrete block for stability.

Figure 1: Defective Pedestrian Crossing (1)

The second example shows a pedestrian crossing where the markings only reach half way across the road. Regrettably, deaths of individuals often result in failures of common sense. If you hear yourself or others saying; *'We already do that',* then challenge that assertion before the Police beat you to it.

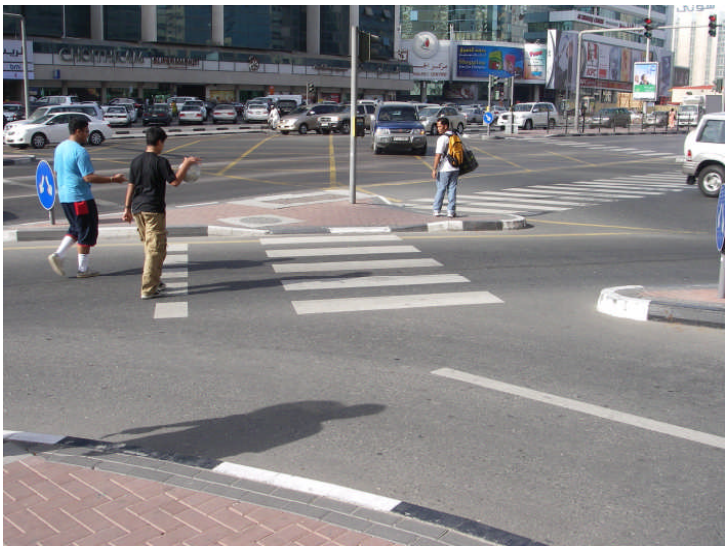


Figure 2: Defective pedestrian crossing (2)

6. SUMMARY

If a serious incident happens today it is probably too late to do anything about it. An organisation will stand or fall on its current policies and procedures, but also, importantly, on how those policies and procedures are implemented and used. By understanding the liability and risk, an organisation can prepare for the unexpected. Don't wait for a Police investigation to expose the gaps in the organisation. Gaps will exist; be proactive to minimise the exposure to risk, and perhaps more importantly, to enhance the health and safety of company employees and those for whom the organisation may have a duty of care.

References:

[1] Department of Environment, Transport and Regions (2000) Tomorrow's Roads – Safer for Everyone. The Government's road safety strategy and casualty reduction targets 2010. HMSO, Norwich.

[2] Department for Transport, Road Casualties: Great Britain 2006 Annual Report. (2007) http://www.dft.gov.uk/pgr/statistics/datatablepublications/accidents/casualtiesgbar/roadcasualtiesgreatbritain2006

[3] Road Death Investigation Manual (2007). National Police Improvement Agency, Wyboston.

[4] Health and Safety Executive (2003) Work-related road deaths: A protocol for liaison, http://www.hse.gov.uk/foi/internationalops/fod/om/2003/103.pdf

[5] Health and Safety Executive (2006) Work-related road traffic incidents: An explanation of circumstances where HSE may have a role to play. http://www.hse.gov.uk/foi/internalops/fod/om/2003/103.pdf