



# QBE

Putting corporate  
manslaughter into  
your management  
system

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# Corporate manslaughter – basic principles

## New offence looks at a way an organisation's activities are managed

*'An organisation will be guilty of the offence if the way in which its activities are **managed or organised by senior management** amounts to a gross breach of the duty of care owed to a person, and that breach results in a person's death'*

*'Breach of duty where evidence shows that there were **attitudes, policies, systems or accepted practices** within the organisation that were likely to encourage any such failure or to have produced tolerance of it'*

*'The intention of the act.....seeks to encourage management to adopt an **approach of collective senior management responsibility** for issues of health & safety that permeates the organisation rather than being concentrated in a single department or individual'*



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# Senior management

Involvement - “attitudes, policies and systems”

- Review organisational factors / responsibilities for H&S
- Display effective leadership
- Functioning management service or lip service
- Appropriate and committed policy

ISO requirement for top management

Information, knowledge or what they ought to have known

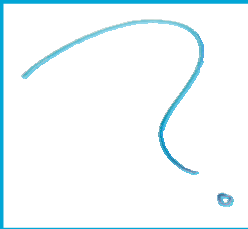


# Management systems

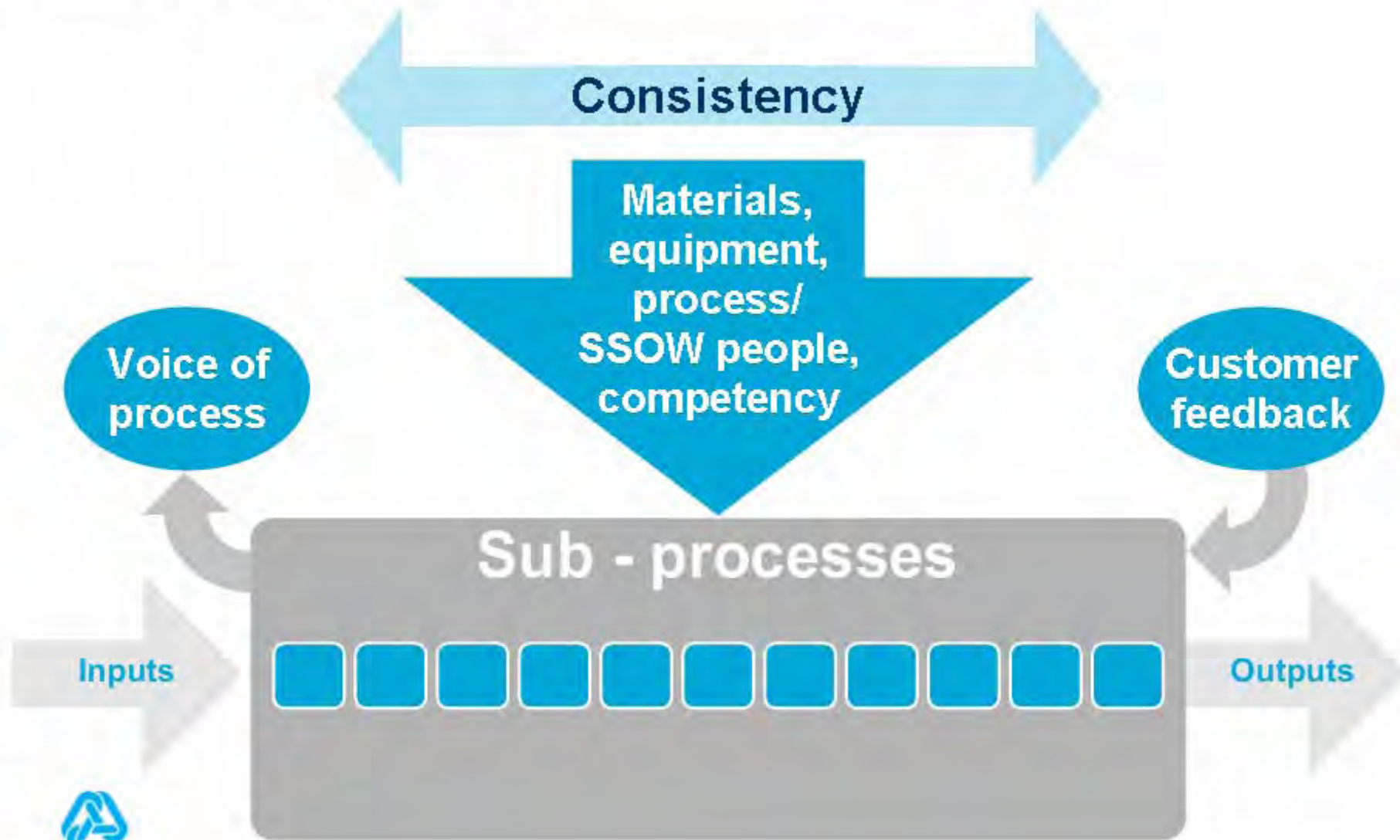
- HSG 65
- ISO 9001
- ISO 14001
- BS OHSAS 18001
- EFQM
- ISO27001
- ISO20000-1

- HSWA 1974
- MHSWR 1999
- Corporate Governance
- Social Accountability
- Financial Reporting

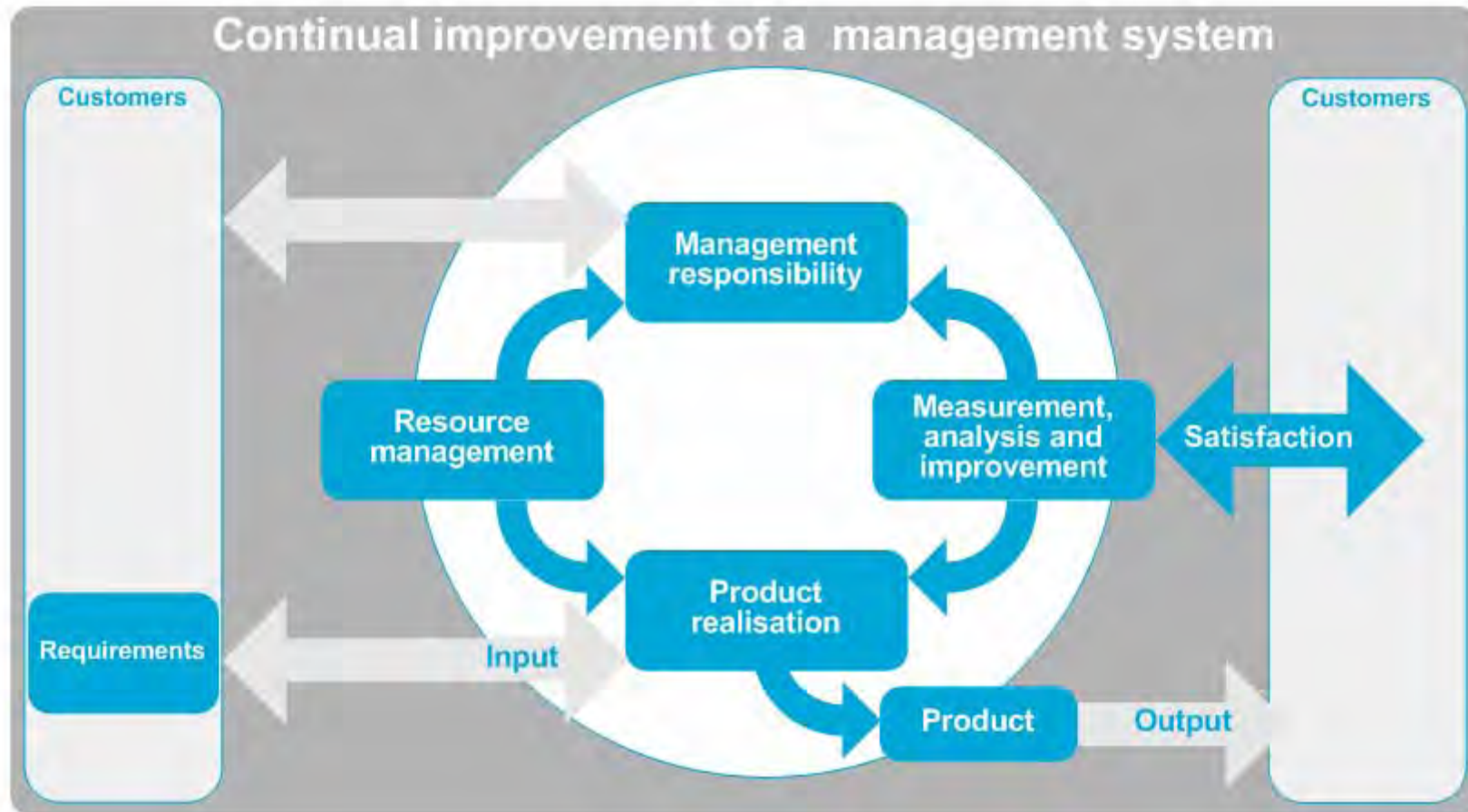
**Confused.....**  
**Are these different?**  
**Compliance or effective**



# What is a process?



# Management process model



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# Plan, do, check, act

## Plan

- Conception to land fill
- Hazard identification, risk assessments e.g. PUWER, WAH
- Implement controls (ERIC-PD)
  - **Eliminate, reduce (substitute), isolate, control, PPE, discipline**
- Safe systems of work, employees and non employees
- Emergency preparedness

## Do

- Documentation; volumes, flow charts, pictures
- Completion of process
- Quality, safety, environment and cash flow
- Records
- Communication

# Plan, do, check, act

## Check

- Collectively review the actions or lack of them on failings....
- Tolerance of unsafe working practices
- Effectiveness of controls
- Audits; compliance and/or effectiveness
- Accident Investigation
- Qualitative versus quantitative
- Monitoring of objectives-trends

## Act

- Proactive v reactive
- Implementation of continual improvement
- KPI's
- Repeat; plan, do, check and act to improve

# Management systems

**Act focus on systemic failures**

**Absence of  
functioning  
system leaves  
organisations  
vulnerable to  
jury criticisms?**

“there is no question of liability where the management of an activity includes reasonable safeguards and a death nonetheless occurs”

# Management systems – 10 key pointers

## Continual improvement

1. Leadership
2. Risk assessment
3. Accident causation
4. Integrated audit
5. Health & safety meetings
6. Training
7. Communication
8. Documented procedures or flow charts (ERIC / KIS)
9. Culture-ownership
10. Targets-KPI's



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## Questions and answers

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