Devonshires solicitors

Health & Safety Brief

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Welcome

Welcome to the summer edition of Devonshires' Health and Safety Brief.

We have a bumper crop of articles for you in this edition. I take a look at investigating accidents, the burden of proof in health and safety matters and one of our recent cases involving fire safety. Nicholas Leigh, also of Devonshires' Health and Safety team, considers Legionnaire's disease and domestic v non-domestic premises.

I am delighted to welcome back to the Health and Safety Brief Stephen Climie, a leading specialist health and safety barrister with Outer Temple Chambers, who takes us through the frankly terrifying new world of penalties under the

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Editorial

Regulatory Reform (Fire Safety) Order 2005 and revisits those contained within the Health and Safety (Offences) Act 2008. Both articles should give those responsible for health and safety cause for thought.

I am equally delighted to introduce a new contributor, Ian Taylor of Fire Consultants Fraigneux, who reminds us of the need to get the fire risk assessment right.

The Health and Safety Brief is written for you, our clients. If there is a topic or area of law you would like to see covered, please contact me or Nicholas Leigh and we shall endeavour to include such an article in our next Brief.

Finally, I am pleased to introduce the Devonshires Health and Safety Audit, a service provided by Devonshires in conjunction with Outer Temple Chambers in which we review all of your health and safety policies and procedures to ensure they are legally compliant, and if they are not, advise on how to bring them up to scratch. For further details, please see page 15.

Happy reading.

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Dealing with a Fire Safety Enforcement Notice

Devonshires recently acted for a large registered provider in relation to an enforcement notice served upon it by the relevant fire authority under the provisions of the Regulatory Reform (Fire Safety) Order 2005 (the "Order").

The fire authority issued the enforcement notice alleging principally that the registered provider had not given consideration to "vulnerable" people living in the relevant building, a block of self-contained flats. Although it had the word "hostel" in the title, it was not a hostel for the purposes of the Order, nor was it a house in multiple occupation. The fire authority required the installation of smoke detectors in the common parts. However, the registered provider had hired fire safety consultants who advised that the best fire safety strategy for the building was "Defend in place" i.e. that in the event of a fire in another part of the building, residents in their rooms would have to stay there until they were cleared to leave. With such a strategy, smoke detectors in common areas were no longer required.

The registered provider opposed such enforcement proceedings on the following grounds. First, the people living in the building were not "vulnerable" as they were over the age of 16 and therefore legally entitled to live by themselves; second, the enforcement notice required the provider to do works that were unreasonable and unnecessary.

The allegations contained within the enforcement notice were appealed and a hearing was set down. In the meantime, negotiations took place between the registered provider and the fire authority.

During the negotiations, several issues were addressed and resolved, with some parts of the notice being withdrawn by the fire authority. Crucially, the fire authority was persuaded that smoke detectors

in the common parts were not required.

The registered provider informed the fire authority that before individuals are given residency, they are screened and categorised to ensure they have no care needs. As the persons in question were not "vulnerable", they should not be separated from the general adult population for fire safety purposes. Despite this, the registered provider agreed to provide training for this specific group, to educate them about the "Defend in place" strategy and other safety strategies, and provided proof that training days were taking place and that those not attending were given training packs and assessed on fire safety procedures.

In light of the above, the registered provider was deemed by the fire authority to be in compliance with the requirements of the Order. The enforcement notice was not withdrawn but rather marked as complied with.

Lessons to be learnt for this case can be divided into two categories: 1. How to avoid an enforcement notice, and 2. What to do if an enforcement notice is received.

1. How to avoid an enforcement notice

The enforcement notice was served by the fire authority due to a lack of information given to the fire safety inspectors, a lack of manuals and procedures to hand and an overall lack of evidence to show concern for fire safety.

To address such problems, a fire safety strategy should be in place, including manuals on training events for fire safety procedures, and such documents should be produced before the fire inspectors' arrival so as to show commitment towards health and safety.

A fire risk assessment report must be commissioned in a timely fashion. While it is arguable that in this case the enforcement notice would have been issued nonetheless, given the other issues related to the case, it would have made dealing with the enforcement notice a smoother process.

Though it may not seem significant, the name and definition of a building can affect its treatment. Care must be taken to ensure that one form of premises is not tagged as another form, such as a block of self-contained flats being referred to as a hostel.

2. What to do if an enforcement notice is received

It is crucial to obtain immediate legal advice in the event that an enforcement notice is served, not least because you have only 21 days in which to appeal against it.

Enforcement notices should not be taken at face value as they are open to challenge on both factual and legal grounds. However, they should be taken seriously and issues raised should be considered.

It is important during litigation for parties to be open to negotiation. Had this case not settled, it would have very likely resulted in a costly procedure, involving an appeal of a magistrates' decision.

Finally, creative solutions can ensure compliance with an enforcement notice, without having to spend vast amounts of money and time disputing the notice itself. In this instance, the provision of special training proved to be sufficient.

"Enforcement notices should not be taken at face value as they are open to challenge on both factual and legal grounds"

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When is a Domestic Premise a Non-Domestic Premise?

Legal advisors are often asked by clients to define the area for which they are responsible for complying with health and safety law. While this appears to require no more than the simplest of answers – you are responsible for your own premises – the differing requirements of various regulations within the health and safety framework can make the actual picture somewhat more ambiguous.

Asbestos

Some legislation, such as the Control of Asbestos Regulations 2006 (the "Asbestos Regulations"), clearly states that the landlord is responsible only for the non-domestic parts of otherwise domestic premises, such as the common parts of blocks of flats. The leaseholder or tenant (the "Occupier") is responsible for their own flat. The landlord has the former responsibility as it has control of access to and responsibility for the maintenance of the common parts. The Occupier has the latter responsibility as they have exclusive possession of their flat.

Substances Hazardous to Health

Earlier legislation, such as the Control of Substances Hazardous to Health Regulations 2002, often does not specify the border of responsibility with such clarity as the Asbestos Regulations. This is partly due to the differing nature of the danger that various pieces of legislation seek to control: asbestos is a construction material the location of which is not going to change whereas substances hazardous to health such as Legionella or chemicals used at work can form or collect suddenly and move about rapidly, with potentially catastrophic results. However, it is also due to a vagueness on the part of those who drafted the law, the intention of which was to allow flexible application in the real world but which inevitably gives rise to circumstances in which opponent parties can be arguing correctly despite having two separate interpretations of the same piece of law.

Devonshires recently acted for a large scale registered provider in a health and safety prosecution which focused on the border between the registered provider and the Occupier's responsibility. The particular governing regulations were unclear as to where the border lay. Devonshires established that responsibility for the cleanliness of items within the Occupier's property, of which failure to clean caused the proliferation of a substance potentially hazardous to health, lay with the Occupier. However, the prosecution argued in the absence of clarity from the relevant regulations that the registered provider was responsible for controlling this potentially hazardous substance within the Occupier's domestic premise, even though to do so ignored the Occupier's exclusive possession, the nature of the scheme in which the Occupier lived and the general rule that health and safety obligations extend only so far as is reasonably practicable.

A landlord can therefore find itself under attack for failing to treat a domestic premise as a non-domestic premise, even when it had no reason to.

"the landlord is responsible only for the non-domestic parts of otherwise domestic premises"

In practice, this means that a landlord is responsible for eliminating or controlling known or suspected asbestos-containing material ("ACM") in the common parts but that the individual Occupier is responsible for dealing with ACMs within their flat. A landlord does not have a legal obligation to enter an adjoining domestic premise to conduct a risk assessment even where it believes that ACMs may be present in that premise, for instance if the tiles in the corridor outside the flat are made of ACMs and appear to continue into the domestic premises.

The only exception is when the landlord must carry out works of repair under its tenancy obligations. If the landlord comes across any ACMs while undertaking necessary repair work to the Occupier's domestic premise, the landlord must manage or control risks arising from these ACMs in accordance with the appropriate health and safety requirements.

Fire Safety

Fortunately, the governing law in one of the most fearsome areas of health and safety, the Regulatory Reform (Fire Safety) Order 2005 (the "Order"), is, like the Asbestos Regulations, commendably clear on the extent to which a landlord is responsible.

Most premises in England and Wales are covered by the requirements of the Order, the key exception being domestic premises, which the Order defines as being "premises occupied as a private dwelling (including any garden, yard, garage, outhouse, or other appurtenance of such premises which is not used in common by the occupants of more than one dwelling".

In other words, the area used exclusively by the tenant does not fall within the responsibilities imposed by the Order, so the landlord need not venture in there or undertake a risk assessment for that premise.

The Overriding Obligation of Sections 2 & 3

When considering the obligations arising under the various regulations, one must always keep in mind the overriding obligation of Sections 2 & 3 of the Health and Safety at Work etc Act 1974, the primary legislation from which the various regulations and orders derive.

Under Sections 2 & 3, an employer must take such steps as are reasonably practicable to ensure the health and safety of those who are on his premise, be they employees or members of the public.

Therefore, common sense must be applied when considering a health and safety risk which may not be caught by the various specific regulations but for which a landlord would be responsible under the wider range of Sections 2 & 3.

For instance, a health and safety risk may emanate from the domestic premise, potentially affecting those who fall within your responsibility. In these circumstances, you would be entitled to rely on your own health and safety legal obligations in order to take action to resolve this risk.

Good Practice

Even when relying on the more clearly drafted regulations, a conscientious registered provider may still feel obliged to take action on behalf of an Occupier – particularly if vulnerable - when it believes that their domestic premise may house a health and safety risk of some kind. When multiplied across hundreds or thousands of individual domestic premises, this may end up costing the registered provider millions.

Good practice suggests that landlords should instruct those who conduct the risk assessments they are obliged to carry out – such as for the common parts of a residential building - to consider whether any areas for which they are directly responsible reveal a point at which there may be a similar risk to the adjoining domestic resident about which the Occupier is likely to know nothing. If the assessment indicates that there is such a risk, the registered provider should inform the Occupier and, where so advised by the risk assessment, the landlord should either undertake to do such works as they are able to themselves or write to the Occupier advising them what they should do.

It is important to be clear that such contact with the Occupier should only arise on the advice of your risk assessment consultant, or else you may end up extending your health and safety control measures way beyond your legal requirements at great cost and with no benefit. The correct advice from your risk assessment consultant will therefore enable you to ensure that not only are you legally compliant but that you have also met with the spirit of the law.

"common sense must be applied when considering a health and safety risk which may not be caught by the various specific regulations"

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Fire Safety Breaches – A New Level of Punishment?

In April 2007 a fire broke out at New Look's Oxford Street store. The fire alarm was activated, the fire brigade called and the building evacuated. The fire resulted in part of Oxford Street being closed. Other stores had to be evacuated - the prosecution suggested that approximately 400 people were evacuated from the store and the surrounding area.

London Fire and Emergency Planning Authority (LFEPA) investigated the incident. The cause of the fire was not determined; it may have been arson. It has never been suggested by the prosecution that New Look's act or default caused the fire.

The investigation took almost two years before LFEPA commenced a prosecution against New Look with various alleged breaches of the Regulatory Reform (Fire Safety) Order 2005 (the "Order"). These charges were eventually reduced to two offences: (1) failure to carry out a suitable and sufficient risk assessment and (2) failing to have in place adequate training. New Look entered a guilty plea to both charges.

On 25 November 2009, New Look was sentenced to pay £400,000 in fines (£250,000 for the risk assessment charge and £150,000 for the training charge), together with £136,000 of costs. In doing so the judge acknowledged that the fine was "substantial" and made several damning remarks about New Look's systems suggesting that the company was "almost dismissive" of its duties.

The company appealed against the fine imposed. New Look was a large clothing retailer, with pre-tax profits of £200 million and annual turnover of approximately £1 billion. The company submitted that in assessing the fine appropriate to the offences admitted, the judge had failed to give sufficient weight to the fact that the breaches of duty were not causative of fire, nor did they cause injury or death. It argued that the fine exceeded levels previously imposed for breaches of the Health and Safety at Work etc Act 1974 ("HSWA"), which for cases of fire precaution regulation appeared in part to mirror the Order, where death had resulted, and that the judge had erred if he had applied a higher presumed standard of seriousness to breaches of fire safety responsibilities than he would for breaches of duties under the Act.

The Order is relatively new and as a result there were no Appeal Court cases on the appropriate fine level. Instead the judge was referred to cases from the wider safety field and specifically from health and safety as guidance. The judge did not however rely on comparable cases from the field of health and safety nor did he make reference to the Draft Sentencing Guidelines Council's guidelines for health and safety cases involving a fatality to give him assistance when setting the fine level.

The result was a fine that was significantly higher than a comparable case in the health and safety field concerned with the degree of risk as opposed to actual harm or injury. New Look argued that the fine was excessive on the basis that the judge failed to take proper account of:

1. the fact that New Look's act or default did not cause the fire - a critical factor in sentencing safety offences;
2. the fact that there was no injury caused - another critical factor in sentencing safety offences;
3. the fact that comparable cases from the field of health and safety impose substantially lower levels of fines;
4. the Sentencing Guideline Council's sentencing guidelines for fatal health and safety cases, which stated that the starting point for fines "will seldom be less than £100,000", whereas for corporate manslaughter the starting point "will seldom be less than £500,000". Although these were still in draft form at the time of sentencing they were in force by the time the appeal was lodged.

Therefore the judge applied a higher standard of seriousness to breaches of fire safety responsibilities than duties under HSWA.

"the judge had failed to give sufficient weight to the fact that the breaches of duty were not causative of fire"

The Court of Appeal's decision

The Court agreed with the Appellant's submission that the Order is a mirror image of the relevant sections of HSWA.

The Court of Appeal concluded that the Crown Court judge had applied the conventional and correct approach described in *R v F Howe & Son (Engineers) Ltd* [1999] 2 All ER 249. In particular it endorsed three particular points considered by the judge: the seriousness of the breach, the defendant's ability to pay a fine and the impact on shareholders or senior managers.

Nevertheless, the Court strongly emphasised that sentencing is a fact-sensitive exercise and will depend on the factual context of each case. Significantly, the Court also acknowledged that the terms of the Order do not imply that fines should be in a different scale to those imposed under HSWA. However, it concluded that "the seriousness of the offence has to be judged by its creation of risk."

While fire in itself is not an aggravating feature of an offence, it does highlight "the potential for serious wider consequences."

The Court therefore concluded that although the fine imposed on New Look was severe, it was not excessive, concluding "the fine imposed was for the magnitude of the risk knowingly taken and not for the causation of any tragic consequences." The Court therefore dismissed the Appeal.

Given the Court's conclusion that the relevant sections of the Order and HSWA are a "mirror image" and that fire is not an aggravating feature, the decision of the Court not to reduce the fine appears to be anomalous. However the reality for multi-site businesses with responsibility for large numbers of visitors to their premises is that the breaches of the legislation will, in the Court of Appeal's opinion, usually be viewed as "a very serious matter" by the Courts.

This case is likely to be referred to by prosecutors in seeking to establish a higher level of punishment following culpable breaches of fire regulations, not least when a fire has actually occurred.

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Requirements of the Regulatory Reform (Fire Safety) Order 2005

The Regulatory Reform (Fire Safety) Order 2005 (the "Order") is the primary piece of fire safety legislation in England & Wales and extends the scope of fire safety law from 'workplaces' to include the communal areas of other buildings such as blocks of flats.

Although there was little immediate reaction to the introduction of the Order, a number of recent and serious fires have focused the attention of regulators, the media and the public. This attention has placed a great deal of pressure on duty holders to demonstrate that they are taking steps to protect residents. There remains, however, much confusion regarding the scope of the Order and how to comply with it.

The overarching requirement of the Order is simple – to take reasonable measures to reduce fire risk to those in and around the premises. The Order contains no prescriptive standards - the required measures should be identified by a fire risk assessment, which should consider possible measures against a fundamental test - are those measures reasonably practicable? If a particular measure is not reasonably practicable in the circumstances, then this can be used as a defence against any enforcement action.

In most cases, the 'significant findings' of the risk assessment must be recorded. A common misunderstanding is that these findings are only those parts of the assessment which require any action. But this is not the case, the significant findings are not only those measures which are required, but also those which are already being taken – the risk assessment should not only record the bad and the ugly, but also the good.

To assist those involved in the risk assessment process, a number of government guidance books have been produced. These guides are just that – useful guidelines against which a building can be assessed. There is no requirement to follow the recommendations of any guide. The technical content of the guidance broadly follows that of Approved Document B, the design guidance for new buildings in England & Wales. Whilst this is useful if you are

risk assessing a new building, for older buildings the guides should be interpreted with care – the intent of the Order is not to improve retrospectively the standard of existing buildings to those expected for new buildings, constructed under current Building Regulations.

Of course, many organisations chose to appoint external consultants to undertake their fire risk assessments. When selecting a third party to assist you with the process, it is vital that you consider more than just their ability to get the job done quickly and cheaply. An unsuitable fire risk assessment could lead to further costs in providing unnecessary fire safety measures, or alternatively in providing additional measures following a subsequent fire service inspection.

The fire safety principles in housing are fundamentally different than those in other types of building, such as offices and shops. Fire risk assessment in housing is a specialist field requiring expert knowledge. Whilst it may be tempting to assume that ex-fire officers will have this knowledge, it should be remembered that prior to 2006, fire services had little involvement with flats and sheltered accommodation – it may be that ex-fire officers have very limited experience in dealing with these buildings.

Any company involved in this area of work should have staff who have chartered fire engineer status, awarded by the Institution of Fire Engineers and the Engineering Council. Chartered status is the ultimate accreditation for many professions; you would expect your structural engineers, surveyors and accountants to be chartered, and you should look for such accreditation when appointing fire consultants.

Despite its simple purpose, the Order can be confusing and is currently subject to much debate. Whilst duty holders are understandably keen to respond quickly to pressure and scrutiny, it is important to make sure that the final risk assessment identifies appropriate measures, in order to satisfy legal requirements whilst avoiding unnecessary costs.

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The Importance of Investigating Accidents Correctly

When a health and safety incident occurs, it is essential that an internal investigation takes place as soon as possible. Where that incident is sufficiently serious (for example it has resulted in a death, serious injury or extensive property damage), a detailed accident report should always be prepared.

Should an enforcement authority investigate – as inevitably they will in the event of a death or serious injury - they will want to see your detailed accident report. The absence of a report will heavily influence any decision the enforcement authority may take to prosecute. Therefore, while there is no strict legal requirement to carry out an investigation, doing so should be a headline requirement of any health and safety policy.

The Investigation Team

It is essential that any large organisation have in place a team of people who can come together quickly in order to carry out the investigation and prepare the report. That team should consist of people who have experience or training in taking witness statements, obtaining and reviewing documents and who have a good working knowledge of health and safety law.

Ultimately, the report has to be comprehensive and effective, but it must also be sensitive to the risk of prosecution. All too often Devonshires' health and safety team are confronted with reports that amount to admissions of criminal conduct when no admission is required and no offence has been committed.

There are thousands of pages of guidance seeking to explain how to carry out an investigation and produce a report. Most of this information is academic, turgid and counter-productive. There are three simple fundamentals which, if followed, will enable you to prepare a report that both satisfies an enforcement authority and provides you with an ability to reduce substantially the risk of such an accident ever happening again: -

1. Determine the facts that led to the accident;
2. Try to establish the cause of the accident; and
3. Set out the lessons learned.

Determine the facts that led to the accident

Those involved or those who witnessed the incident should give a witness statement to the investigation team as soon as possible after the incident has occurred. Speed is important as memories fade quickly.

Taking a witness statement involves interviewing the witnesses, asking them to explain in as much detail as possible exactly what happened in their own words, and testing their knowledge and understanding of the incident along the way.

You should also obtain any relevant documents, such as photographs and plans. If the incident involved (as it often does) a piece of machinery, obtain the service history, specification and any other relevant document that may assist you in assessing its performance or condition.

“Speed is important as memories fade quickly”

Once you have the facts to hand you can start to prepare the report.

Try to establish the cause of the accident

In real life, accidents happen due to a combination of otherwise unconnected events rather that one act in isolation. All the facts that led to the incident, from the underlying causes to the root cause itself, should be analysed. Most incidents start with a very small action or mistake (such as a failure to lock a door, put on a handbrake or turn off a power switch) that would normally be considered insignificant on its own. Yet a chain reaction may occur which leads from this otherwise unimportant moment to a potentially very serious accident. Once the factual matrix is understood, the underlying and root causes of the incident should become clear.

One should always keep in mind the duty to carry out one’s undertaking in such a way that everything reasonably practicable is done to protect the health and safety of employees and others on the premises. The drafting of the report should be sensitive and alert to that primary health and safety duty.

Set out the lessons learned

Once you have formed a view as to the cause of the incident, you must then turn your mind to what could (or should) have been done to identify the risk or risks that led to it. This in turn may give rise to a change in your health and safety policy, require targeted training or lead to updating a risk assessment. Not all risks can be taken into account, life is not that straightforward, and not all incidents can be prevented simply because a potential danger has been identified in a risk assessment. Nevertheless, lessons should be directed at preventing or minimising the cause of the incident. In that regard, they should be targeted and specific.

The Report

Your accident report should be thorough and considered, deal with the three fundamentals and be prepared with one eye on the possibility of prosecution. It should use the evidence obtained in your investigation as a basis on which to make a clear assessment of what happened.

Getting all of these elements right is not easy and takes both time and experience. If you would like some training or assistance in the preparation of accident reports, please do not hesitate to contact the writer.

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The Calculation of Fines

The Health & Safety (Offences) Act 2008 (the "2008 Act") came into force on 16 January 2009. It arrived on the statute book after a smooth passage through Parliament and little publicity. The 2008 Act does, however, have considerable implications for those faced with prosecution under the Health & Safety at Work etc Act 1974 ("HSWA") and/or regulations made thereunder.

In summary, the 2008 Act makes three key changes:

1. It brings the penalties for breach of statutory duty of relevant legislation into line with those for breach of the key provisions of HSWA (Sections 2-7);
2. It gives the option of a term of imprisonment; and
3. It makes certain offences that can currently only go to trial in the Magistrates Court, triable in either the Magistrates or the Crown Court.

To take an example – an employee is injured whilst assisting with a lifting operation. The lifting operation has not been properly planned and supervision is inadequate. The employer is prosecuted for breach of Section 2 of HSWA and for breach of Regulation 8 of the Lifting Operations Regulations 1998 (the duty to ensure that lifting operations are properly planned, supervised and carried out in a safe manner). The employer pleads guilty to both offences. The offences are such that the employer can be sentenced in either the Magistrates Court or the Crown Court depending upon whether the Magistrates consider their sentencing powers to be adequate. More serious injuries are often the basis for Magistrates' Courts declining jurisdiction and committing the case to the Crown Court.

For an accident occurring prior to 16 January 2009, the maximum penalties applicable to the above offences are as follows:

Offence	Magistrates Court	Crown Court
Section 2 HSWA	£20,000	Unlimited fine
Reg 8 LOLER	£5,000	Unlimited fine

For an accident occurring on or after 16 January 2009, the maximum penalties are as follows:

Offence	Magistrates Court	Crown Court
Section 2 HSWA	Imprisonment for a term not exceeding 6 months, or a fine not exceeding £20,000, or both.	Imprisonment for a term not exceeding two years, or an unlimited fine, or both.
Reg 8 LOLER	Imprisonment for a term not exceeding 6 months, or a fine not exceeding £20,000, or both.	Imprisonment for a term not exceeding two years, or an unlimited fine, or both.

The 2008 Act, therefore, significantly raises the stakes. This is particularly so for individuals, including directors or managers of corporate defendants who face prosecution under Section 37 of HSWA – where the offence is committed with their consent or connivance or is attributable to their neglect – and face the risk of imprisonment.

On the positive side, the increased penalties in the Magistrates may assist in persuading the Magistrates to accept jurisdiction, thus limiting costs and providing an early resolution in appropriate cases. Taking the above example, if the employer pleads guilty at the first opportunity and as a result secures a one third reduction in sentence, the Magistrates would have to conclude that a fine of £60,000 would not be sufficient, in order to pass the case up to the Crown Court. The downside is that fines will almost certainly be higher. That is of course the real objective of the 2008 Act so as to "punish the criminally negligent who put life and limb in danger in the workplace, and to deter those who are tempted to cut costs by breaking the law".

The Sentencing Guidelines Council guidance for health & safety and corporate manslaughter offences can be found at http://www.sentencing-guidelines.gov.uk/docs/guideline_on_corporate_manslaughter.pdf

Corporate defendants will be relieved that fines are not to be set on the basis of the Sentencing Advisory Panel's ("SAP") proposals on offences involving death. SAP had proposed that the starting point on fines for fatalities prosecuted under HSWA should be 2.5% of the guilty company's annual turnover (when calculated over a 3 year average), with the actual fine being between 1% and 7.5% of that company's average annual turnover depending upon the aggravating and mitigating factors. The proposed starting point for fines under the Corporate Manslaughter & Homicide Act 2007 was 5% of average annual turnover with the fine being fixed at between 2.5% and 10%, again dependent upon aggravating and mitigating factors. The effect could have been startling.

For example, at 2.5% of the company's average annual turnover, the fine imposed upon Network Rail in March 2007 would increase from £4m to almost £97m. The fine imposed on Corus UK in August 2007 would increase from £100,000 to £252m.

Nonetheless, the net result of this guidance and the 2008 Act will be higher penalties.

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A Point to Prove

Health and safety law is an unusual beast. The burden of proof is not quite the same as in normal criminal cases - and yes, health and safety offences are categorised as criminal. It is therefore important that those who need to consider health and safety obligations understand how the burden of proof operates in this area of law.

In order to illustrate the position, I have limited the following discussion to Sections 2 and 3 of the Health and Safety at Work etc Act 1974 ("HSWA") as these are the primary health and safety duties owed by an employer, a breach of these duties being the most common under health and safety law. For those who are unfamiliar with them, Sections 2 and 3 provide as follows: -

Section 2(1): It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.

Section 2(3): It shall be the duty of every employer to prepare and as often as may be appropriate revise a written statement of his general policy with respect to the health and safety at work of his employees and the organisation and arrangements for the time being in force for carrying out that policy, and to bring the statement and any revision of it to the notice of all of his employees.

Section 3(1): It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not exposed to risks to their health or safety.

The HSWA acts as the 'Parent' legislation for the myriad of regulations that are enacted under it, such as the Management of Health and Safety at Work Regulations 1999, the Control of Substances Hazardous to Health Regulations 2002 and the Control of Asbestos Regulations 2006. It also provides the Health and Safety Executive with the authority to issue legally-binding codes of practice, for instance the Control of Legionella Bacteria in Water

Systems Approved Code of Practice L8.

A breach of these regulations and any failure to comply with an Approved Code of Practice can be a breach of the primary duty and will likely lead to a prosecution under Section 2 or 3 of HSWA.

In order for the prosecution to secure a conviction under Section 2 or 3, it need do no more than establish that there was a risk to the health and safety of that person. There is no requirement for death, injury or loss. Having been presented with an allegation it is then for the accused to demonstrate that he has done everything reasonably practicable to protect the health and safety of his employees and those affected by his undertaking.

Before looking at what "reasonably practicable" means, let us consider more carefully the concept of "risk" and what the prosecution needs to do in order to establish the existence of a risk.

Risk

In *R v Chargot Ltd and others* [2009] 1 W.L.R. 1, the House of Lords held that first and foremost a risk must be foreseeable. In *R v Porter* [2008] EWCA Crim 1271, the Court of Appeal held that a risk must be real and represent a material risk to health and safety. It cannot therefore be fanciful or remote. So, in simple terms, the prosecution must establish that the risk is material and foreseeable.

In most cases, the fact that an incident has occurred will be enough to establish the risk. In others, it is more subtle. For example, a failure to have in place a suitable and sufficient risk assessment does amount to a risk to the health and safety of an employee and non-employee, even though no injury or loss may have occurred.

The burden of proof is not a difficult hurdle for the prosecution which is why the vast majority of cases result in a conviction. Once the prosecution have established the existence of a risk, the only way an accused can beat the charge is by proving that it did everything reasonably practicable to protect its employee or non employee against the risk.

"Reasonably Practicable"

This need to prove that you have done all that you reasonably can is why health and safety lawyers talk about a reverse burden of proof. Once a prima facie case has been established by the prosecution, the onus falls squarely on the accused to disprove their alleged culpability. In reality this is a difficult hurdle to overcome. There is usually something more an employer could have done.

One of the few ways in which the law helps the accused is by imposing a requirement of reasonableness on the steps it could have taken. So, if the only way the incident could have been prevented was to do something that might otherwise have been unreasonable, the prosecution will fail.

For example, a metal girder may protrude from a ceiling. Someone hits their head on it. The risk from further injury cannot be removed unless the entire ceiling is lowered or the girder removed, either course of action costing tens if not hundreds of thousands of pounds. In these circumstances, placing a sign alerting passers-by to the low girder would be a reasonably practicable alternative to vastly expensive works.

By contrast, it would be wholly unreasonable to fail to fix a broken tap in a building that leaked water into a corridor used by many people. Here the cost of fixing this tap is small and the risk of causing danger to others from slipping on the water significant.

So there you have it, the burden of proof in health and safety cases. It is unusual, and it places a considerable and often impossible burden on the accused to prove that it did everything it reasonably could. The ease at which a prosecution can be brought must always be borne in mind by those working in the health and safety field. It does not take much to find yourself in the Crown Court.

"In most cases, the fact that an incident has occurred will be enough to establish the risk"

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A Recent Case of Note

Devonshires recently acted for a large registered provider in a matter that shows how, like a small fire, a minor health and safety error can be conflated by prosecutors into a potential inferno.

In 2007, a resident of the registered provider was hospitalised and diagnosed as having, amongst other illnesses, Legionnaire's disease.

Legionnaire's disease is a virulent form of pneumonia which affects vulnerable people in particular. It is contracted by inhaling Legionella bacteria carried by water and water vapour. Therefore, water systems must be maintained correctly to ensure that Legionella is denied the conditions in which to thrive.

The resident was discharged from hospital but died one month later as a result of several potentially fatal conditions related to old age. Legionnaire's disease was not noted as the cause of death.

No other resident had contracted Legionnaire's disease. However, in diagnosing the existence of the disease, the hospital was obliged to inform the resident's local authority. The local authority conducted an investigation and raised Legionella counts were found within the resident's flat.

The registered provider undertook extensive measures across the entire scheme to reduce the risk of further exposure. Indeed, there have been no other reports of Legionnaire's disease at this or any other scheme owned and/or managed by this registered provider.

Health and safety law requires that those responsible for premises examine the water system within those premises to establish what action must be taken to manage and reduce the risk of Legionella proliferation. This examination is carried out by way of a risk assessment, a pivotal requirement of the Control of Substances Hazardous to Health Regulations 2002 ("COSHH") and the Approved Code of Practice, which were both applicable in this case.

COSHH requires that a suitable and sufficient risk assessment be undertaken to establish what risks to health and safety may arise from the presence of potentially hazardous substances within an undertaking. COSHH then requires that you undertake such precautionary measures as are advised by the risk assessment to ensure that the risks identified are sufficiently removed or controlled.

The local authority's investigation identified a failure on the part of the registered provider to have in place a Legionella risk assessment for a period of three years leading up to the incident. The registered provider had contracted one company to undertake risk assessments across a number of its schemes. Ultimately, there was a delay, and delivery of the risk assessments fell behind schedule. The registered provider made some attempts to chase the risk assessment, which was eventually delivered two months before the resident was hospitalised.

Following its investigation, the local authority decided to prosecute the registered provider under Section 3(1) of the Health and Safety at Work etc Act 1974. This provision states that it is "the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected (by conduct on the premises of his undertaking) are not thereby exposed to risks to their health or safety."

"water systems must be maintained correctly to ensure that Legionella is denied the conditions in which to thrive"

Despite the title of the Act, this section extends a registered provider's health and safety responsibilities to all those are on its premises and who are not its employees. Therefore, while the registered provider's obligations do not extend to individual domestic premises, the common parts of blocks of flats such as halls, common rooms and communal kitchens and toilets do form part of the registered provider's undertaking, and so the registered provider is responsible for ensuring compliance with health and safety law in these areas.

Despite the charge, the registered provider had never sought to deny that raised Legionella counts were found inside the resident's flat. However, these raised counts arose from a failure to keep taps in the apartment clean. While the registered provider had the usual maintenance and repairing obligations,

it was not obliged to ensure hygiene within the resident's flat. This was not a care home but a lower category form of sheltered accommodation in which emergency assistance was on hand but not to clean residents' homes.

Despite this, the prosecution sought to claim that the registered provider's failures caused the death of the resident by exposing her to Legionella.

Devonshires provided extensive advisory services and negotiated with the prosecution on behalf of the registered provider. Their first act was to persuade the prosecution that they were unable to prove the causal link between the fact of the resident's exposure to Legionella and the fact of her death. The resident did not die from Legionnaire's disease. Furthermore, she was discharged from hospital following treatment and had numerous other illnesses, any of which could have caused her death.

The prosecution agreed to remove this allegation from its Prosecution Summary. Instantly this reduced the registered provider's potential liability. Health and safety prosecutions where death is proved to have resulted from a breach of the primary duty can carry fines of hundreds of thousands of pounds and can damage the reputation and credibility of an organisation, especially if that organisation's task is to provide support to the vulnerable. Individuals can also be fined and / or sent to jail in the most serious cases.

Having removed this highly contentious point, the prosecution nevertheless continued to assert that the registered provider was responsible for exposing the resident to Legionnaire's disease even if that disease did not cause her death. The registered provider was therefore caught in a dilemma: fight the case and be found guilty due to the presence of the one charge element it could not defend or negotiate a plea until the charge was acceptable and the registered provider could plead guilty.

Central to the prosecution's case was the assertion that the registered provider had an obligation under health and safety law to undertake a risk assessment in respect of each and every individual domestic premise under its ownership and / or control.

However, following further negotiations, the prosecution also dropped this assertion, accepting that registered providers should only seek to investigate an individual domestic premise if their risk assessment of the common parts indicated that they should do so. In such circumstances the leaseholder or tenant (the "Occupier") would be under no obligation to let the registered provider into their premises, and that in the absence of such access, a letter to the Occupier warning them of this risk would be enough to discharge their obligation arising from the risk assessment's advice.

In dropping this assertion, the case was no longer in danger of setting a precedent that would have been extremely onerous for registered providers and other providers of housing en masse, namely that a provider which may have a thousand or ten thousand individual domestic premises under its control would have to spend £500 per premise in order to obtain separate risk assessments for each and every one of them, costing millions.

"the registered provider would have been charged with and potentially convicted of causing the death of a tenant through no fault of its own"

Negotiations also ensured that the case stayed in the Magistrates Court rather than be committed to the Crown Court. Therefore, with a much lower profile, the potential sentence was limited and the case aroused virtually no interest in the press nor caused any commotion. The registered provider received a modest fine for its failure to have the risk assessment in place – as known, and as expected.

This case concluded very successfully for the registered provider. However, if the prosecutor had had its way, the registered provider would have been charged with and potentially convicted of causing the death of an Occupier through no fault of its own. It is therefore clear that a prosecutor can escalate a minor health and safety breach into a potentially vastly damaging case in which a registered provider's terrific health and safety record may turn to ashes.

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The Devonshires / Outer Temple Chambers
HEALTH & SAFETY AUDIT

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companies and / or individuals can be prosecuted

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- Review your risk assessments
- Advise you on all necessary improvements to ensure that you are meeting all of your legal health and safety obligations

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