Focus on… the Corporate Manslaughter and Corporate Homicide Act

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This guidance has been produced to alert GPs to the details of the Corporate Manslaughter and Corporate Homicide Act 2007, which came into effect on 6 April 2008 and applies to organisations, including NHS bodies across the UK. It was introduced in response to high-profile disasters such as the Potters Bar and Paddington train crashes, which highlighted the difficulty of securing criminal prosecutions against large corporations. It takes into the area of responsibility such things as accidents when driving to work, MRSA cases and any work place fatality caused by the practices "gross breach" of duty of care. The act will facilitate the prosecution of organisations as a whole and not individuals, whether doctors or other members of staff. Individuals remain liable under existing health and safety legislation and the common law of manslaughter. The offence is known as Corporate Manslaughter in England, Wales and Northern Ireland, and Corporate Homicide in Scotland.

Duty of care

To be liable, an organisation must owe a 'duty of care' to the victim. In the case of a doctor's surgery, both patients and staff are owed a duty of care. A failure to provide this duty of care which results in death would be liable under the new legislation if it is the result of the ways in which the organisation has been managed or organised. The act emphasises that to liable under this act, senior management's organisational or managerial conduct would be a 'substantial element in any breach of the duty of care leading to death. This could be the result of 'attitudes, policies, systems or accepted practices within the organisation', and includes and construction or maintenanace work taking place on the premises.

The act does not affect prosecutions to individuals under existing health and safety law.

It must be a 'gross' breach of the duty of care, falling well below what could reasonably be expected. Juries may consider the extent to which an organisation was in breach of its obligations under the existing health and safety law.

Between 2002 and 2005 seven people died after falling or jumping from windows in NHS buildings. In each of these cases the window restrictor was faulty or missing. Had the new law been in place, corporate manslaughter charges could have been made in each of these cases. This highlights the importance of evaluating every aspect of the day-today running of a practice with the Corporate Manslaughter Act in mind.

Sanctions

- An unlimited fine.

- A remedial order- requiring the organisation to take specified steps to remedy, at the request of the prosecution.

- A publicity order- making the details of the offence publicly available in a manner considered acceptable to the court.

What should practices do?

In light of the new legislation, it is important for practices to take a number of steps:

- Carry out a review of health and safety processes and documentation. Are current processes sufficient? Ensure that your practice policy on the Health and Safety at Work Act (HASAW) promotes a safety conscious culture.

- Ensure that staff training and development is adjusted to promote awareness of the new legislation and its potential ramifications. Do not inappropriately delegate responsibilities to staff without proper health and safety training and ongoing backup and support.

- Job descriptions for all staff will need to be reviewed to upgrade the emphasis on health and safety and the joint responsibility for all working at your practice to take a positive approach to health and safety.

- Check that the partners agreement/contract specify health and safety responsibilities, which Partner has the lead for any specific areas of health and safety including clear and specified sanctions for the neglect of these duties/responsibilities.

- Review the management of hazardous substances- if a child were to die following accidental consumption of a toxic substance at a consultation, the absence of a sufficient drug safety policy could mean vulnerability to a conviction.

- Review whistle-blowing policy. There should be protocol for handling reports of any behaviour that could lead to prosecution under the Corporate Manslaughter Act.

- Consider how to learn from significant events that did not, but could potentially have caused death. Ensure that all possible measures are taken to prevent the recurrence of such events.

- Any expenditure on improvements to safety must be recorded and kept for future reference. Check that the practice insurance cover is adequate to protect for such events. This may well mean an increase in annual cover charges or the redrawing of your current Insurance cover to include potential litigation claims and damages