

Health and Safety Brief

Summer 2011



In this issue

| | |
|---|----|
| The Coalition's approach to health and safety | 2 |
| A policy for policies – What your health and safety policy should contain | 5 |
| Legionella risk assessment: BS 8580:2010 | 7 |
| Corporate manslaughter: The first conviction | 8 |
| A flue with a view – Recent changes in gas safety guidance | 10 |
| Group structures – Where does responsibility lie? | 13 |
| The changing regulatory system of the care sector | 14 |
| Recent cases – Marble City | 15 |

Welcome

Welcome to the Summer 2011 edition of the Health and Safety Brief. Once again we have a wide and varied range of articles for you.

In this edition, we consider the rather vague and ambiguous noises being made about changes to health and safety law by the Coalition Government. We also look closely at the impact the new Gas Safe Register Guidance TB008 will have on Registered Providers (RPs) and what needs to be done now to address this.

As always, we look at important recent cases, such as HSE v Marble City Ltd, which looks at sentencing guidelines, and Cotswold Geotechnical Holdings, in which the first conviction under the Corporate Manslaughter Act 2007 was imposed.

Welcome

The editorial team are delighted to welcome on board Karen Howell, Head of Health and Safety at care providers The Abbeyfield Society, who examines the interaction between the Health and Social Care Regulations and Care Quality Commission Regulations.

In an age of restructuring, we consider the vexed question of where health and safety responsibility lies and look at what a proper health and safety policy should include.

I do hope you find this edition of the Health and Safety Brief informative and enlightening. As always, it is written with our clients and the sector in mind. If there is anything you would like us to cover in the next edition, please do let us know.

Have a healthy and safe summer!

Mark London, Partner and Head of Construction and Health and Safety at Devonshires



2

The Coalition's approach to health and safety

Since its formation in May 2010, the Coalition Government has promised (or threatened, depending on your point of view) to rein in what it perceives to be wholly unnecessary regulation in a wide variety of areas. Health and safety has been a particular target, favoured as it is by media reports of myths of excess, for instance that games of pin the tail on the donkey are banned as they present a risk. On 21 March 2011, Chris Grayling, the Employment Minister, announced the Coalition's new approach in a report called *Good Health and Safety, Good for Everyone* (the Report). For Registered Providers of Social Housing (RPs), any root and branch change to health and safety law is one that must be taken very seriously. But, despite the Coalition's tough talk, does the Report really amount to a radical change, or is it rather like Lord Young's report, in which rhetoric about health and safety gone mad filters down to very little substantive change?

The Report certainly presents a robust attitude. It starts off by saying that "a key part of our deregulatory agenda is changing the health and safety culture that causes so much frustration in Britain today... The burden of health and safety red tape has become too great, with too many inspections of relatively low risk and good performing workplaces, frequently poor health and safety advice to businesses from badly qualified consultants, and a complex structure for regulation. The time has come for all of this to change."

The Report goes on to say that "the current health and safety system in Great Britain came into being with the Health and Safety at Work etc Act 1974, based on the sound principle that those who create health and safety risks in the workplace have the responsibility to manage those risks 'as far as is reasonably practicable'. Over the following decades, however, a plethora of legislation has grown up. There are now 17 Acts owned and enforced by the Health and Safety

Executive (the HSE), and over 200 Regulations owned and enforced by the HSE / Local Authorities. The sheer volume of health and safety regulation can lead to confusion and uncertainty for businesses.”

The Report concludes, in respect of legislation, that the Government “will set up an immediate independent review of health and safety regulation...The review will provide its recommendations by Autumn 2011. The Government will then decide what actions to take in the light of those recommendations”. The review is to be conducted by Professor Ragnar Löfstedt, Director of the King’s Centre for Risk Management at King’s College London, who will be supported by an independent advisory panel made up of leading politicians with appropriate experience, business people and employee representatives. Whether or not it is able to identify regulations which ought to be repealed is something we will report on once the review has been concluded.

repeal of the Control of Substances Hazardous to Health Regulations 2002 or the Control of Asbestos Regulations 2006, or find that the system of risk assessment followed by control measures followed by monitoring and review is inappropriate and ineffective. Meanwhile, the Bill is in the earliest stages of the parliamentary law-making procedure, and is not sponsored by the Government. It is highly unlikely that it will become law.

Beyond legislative considerations, the Report heralds the creation of the Occupational Safety and Health Consultants Register (the OSHCR) and the reduction by one-third of proactive inspections to be undertaken by the HSE.

The OSHCR may become the register of competent consultants the health and safety sector has been crying out for. Or it may not. The Report is correct to identify the need to “clamp down on the rogue health and safety advisers who cost industry so much money by giving them advice which bears little relation to the

“The OSHCR may become the register of competent consultants the health and safety sector has been crying out for.”

3

There is also a forthcoming private members bill (the Bill) which targets the primary Act: the Health and Safety at Work (Amendment) Bill 2010-11, sponsored by Christopher Chope, Conservative MP for Christchurch in Dorset. The Bill seeks to “amend the Health and Safety at Work etc Act 1974 in respect of systems of risk assessment; to make provision for separate requirements for play, leisure and work-based activities; to introduce simplified risk assessments for schools; and for connected purposes.”

So what should an RP make of such radical changes? Well, competent persons appointed to satisfy their employer requirements under health and safety law need not tear up their health and safety policies, practices and procedures just yet. Nothing is going to change in the short term, and such deregulation that does occur is likely to be gentle rather than revolutionary. After all, it is hard to imagine that Prof Löfstedt will recommend the

actual requirements of legislation.” Registration is voluntary, open to “health and safety practitioners who are properly accredited to one of the professional bodies in the industry.” In order to be registered, “applicants must be a member of a UK health and safety professional body and have a degree level qualification, a minimum of two years experience and engagement with a continued professional development scheme. This is usually at Chartered, Fellow or Registered Member status.” Should a registered consultant “fail to maintain the high standards of the register, (they) will be subject to the disciplinary procedures of their professional bodies and - if a decision to withdraw the membership status is made - the consultants will no longer be eligible to appear on the register.”

The OSCHR can be found at www.oshcr.org and already has almost 2,000 registered consultants. If the OSCHR forces the incompetent consultants out of business, that will be good news for all

in the field. However, there will be a risk that the OSCHR, initially at least, provides those who offer poor services another way of reaching more clients. In the meantime, health and safety advisors remain best placed to offer advice on quality consultants. This is particularly the case for RPs who have large complex premises and thousands of people within them.

In reducing the amount of inspections to be undertaken by the HSE, the Coalition seeks to “shift the focus of health and safety activity away from businesses that do the right thing, and concentrate on higher risk areas and on dealing with serious breaches of health and safety regulation.” It intends to achieve this by:

- “Focusing on better health and safety outcomes and not purely technical breaches of the law.
- Making it as straightforward as possible for business, and in particular, small businesses, to deliver a healthy and safe working environment.

may have saved that person's life, and saved themselves from huge financial and reputational damage.

The Report has established the following categorisations of health and safety risk:

- “Comparatively high risk areas where proactive intervention is to be retained. The major areas for inclusion are currently considered to be construction, waste and recycling, and areas of manufacturing which are high risk e.g. molten and base metal manufacture.
- Areas of concern but where proactive inspection is unlikely to be effective and is not proposed e.g. agriculture, quarries, and health and social care.
- Lower risk areas where proactive inspection will no longer take place. These areas include low risk manufacturing (e.g. textiles, clothing, footwear, light engineering, electrical engineering), the transport sector (e.g. air, road haulage and docks), local authority

“However, the system is prescriptive, with prevention being better than cure.”

4

- Ensuring health and safety law is enforced in a manner which is proportionate to risk.
- Avoiding placing unnecessary burdens on businesses which manage health and safety effectively.
- Maintaining a strong deterrent against those who fail to meet their health and safety obligations and put their employees at material risk thereby also deriving an unfair competitive advantage.”

Those involved in health and safety compliance practice recognise that enforcing authorities can sometimes become fixated on the potential threat posed by a technical breach – for instance not having a risk assessment in place – rather than a case of death or serious injury. However, the system is prescriptive, with prevention being better than cure. Employers will enter dangerous waters if they wait until someone has died before they realise that resolving the technical breach

administered education provision, electricity generation and the postal and courier services.”

RPs, particularly those with a care element, are most likely to find themselves in the second category, i.e. an area of concern where proactive inspection is unlikely to be effective. The Report says that the “HSE will reduce its proactive inspections by one third (around 11,000 inspections per year) through better targeting based on hard evidence of effectiveness based on these categorisations.” It also states that “the Government believes that it is right to apply similar principles to local authority health and safety activities. It will look to see a reduction of at least a third (65,000 per annum) of inspections and greater targeting where proactive inspection continues.” Of course, this does not mean that health and safety need no longer be a priority for RPs. Whilst the HSE may not undertake as many random checks, in the event of a death or

serious injury, the relevant emergency service will still report the incident to the HSE, who will still investigate. Health and safety failures will still most likely result in a prosecution. So, once again, the changes appear to generate no change at all.

What this flurry of activity means is that, rather like Lord Young's report, noise is being made but the structure of health and safety law looks as if it will be left intact. Naturally, the outcome of Prof Löfstedt's review will be of particular interest to legal advisors, but those who work in health and safety law on a day-to-day basis understand what critics of the system do not: it is in fact nimble rather than over-regulated. There are many specific areas of possible risk, which apply to some sectors and not others. Just as it would be inappropriate to demand that small businesses undertake disproportionately expensive risk assessments, so it is equally lax to allow a large organisation to provide insufficient attention to its risk profile by under-regulating.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk

A policy for policies – What your health and safety policy should contain

5

Whilst there is a general awareness of the need for an employer to have a health and safety policy for premises under its control, we often find that there are wide discrepancies in the content of the policies we are asked to review.

It may appear to some that the need for a health and safety policy is a regulatory box to tick and ultimately amounts to no more than a bundle of paper which is thrown into the bottom of a drawer, only to be pulled out when the Health and Safety Executive (HSE) come knocking at the door. This is not the case. The HSE will always ask to see the policy in the event of an investigation. If a Registered Provider (RP) is unable to provide an adequate policy and demonstrate that it is understood and enforced, it will dramatically increase the chances of prosecution.

It is therefore paramount that the policy be successful. In order to achieve this, RPs should consider their health and safety policy as the starting point for all of their subsequent health and

safety practices and procedures, and the way by which they can communicate their health and safety compliance regime to their staff. The policy should make clear:

- The RP's general obligations under health and safety as an employer
- A method for complying with those obligations

Therefore, a health and safety policy should include, amongst other items:

1. A clear expression of the threshold that health and safety law requires the RP to meet, i.e. the standard of reasonable practicability.
2. How the RP determines what "reasonably practicable" means in the context of risk avoidance measures it should take in each and every part of its undertaking. In other words, a requirement that the RP carries out suitable and sufficient risk assessments for all of the premises for which it is responsible.

3. How the recommendations made in the risk assessments will be implemented, reviewed and monitored, including what to do if the risk profile of a particular premises changes.
4. The health and safety compliance structure within the organisation, detailing how and by whom decisions are to be made in respect of the RP's health and safety policy, practices and procedures, and how are these decisions are to be implemented across the RP's premises.
5. The specific responsibilities of those referred to in the compliance structure.

Any structure outlined must be approved by the RP's senior management (including the executive and the board as appropriate) so that those who are responsible for implementing its requirements are fully aware of what they are. All structures should be as simple as possible. However, where the health and safety requirements of the employer's premises demand a more complicated

your current policy and offer advice as to how we believe your policy can be improved.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk

“Perhaps inevitably, preparing a health and safety policy can be more complicated than first appears.”

6

arrangement, clarity should be the watchword. If guidance in the workability of a policy is required, RPs should not hesitate in seeking professional advice.

Once agreed to by the organisation, the policy must then be implemented. There will be no credit from an enforcing authority if an RP has an excellent health and safety regime on paper yet unsupervised children are using saws in workshops.

Perhaps inevitably, preparing a health and safety policy can be more complicated than first appears. RPs must remember that the policy is there to enable it to comply with its legal health and safety obligations. Therefore, it must focus on methods by which these obligations can be met. Devonshires provides numerous services in respect of health and safety policies. We can advise you on what your policy should contain, we can even draft a policy for you or we can review



Legionella risk assessment: BS 8580:2010

Despite the keystone importance of risk assessments within the field of health and safety law, legislators and enforcement authorities have preferred not to proscribe the form they should take. There is a little guidance in risk-specific regulations, approved codes of practice and also more generally in the Management of Health and Safety at Work Regulations 1999. However, whether or not the risk assessment you or your consultant has undertaken could survive scrutiny in the event of an investigation is often a cause for concern. Therefore, it is with great interest that health and safety practitioners welcome BS 8580:2010 (BS 8580), the British Standards Institute's code of practice for carrying out a legionella risk assessment.

Published at the end of last year, BS 8580 states before all else that "compliance with a British Standard cannot confer immunity from legal obligations". This is true – the legal requirements in respect of legionella are those contained in the Health and Safety At Work etc Act 1974,

- Contamination – the underlying source of the legionella
- Amplification – the conditions which may cause the legionella to proliferate to dangerous levels
- Transmission – how the legionella may be spread
- Exposure – how people might inhale the legionella
- Host susceptibility – how likely are those within the premises to contract Legionnaire's disease if exposed.

The specific areas of risk deal with issues that should be considered for all water systems and, in greater depth, particular areas of concern such as cooling towers and spa pools.

BS 8580 contains numerous points of good practice, and notes to assist understanding of the guidance, including warnings as to common faults that have occurred in the past. The focus is on

“Published at the end of last year, BS 8580 states before all else that compliance with a British Standard cannot confer immunity from legal obligations.”

7

the Control of Substances Hazardous to Health Regulations 2002 and ACoP L8 (the control of legionella bacteria in water systems). What BS 8580 does seek to do is expand the means by which those tasked with health and safety legal obligations can meet them. Due to the influential status of the guidance issued by the British Standards Institute, there is no doubt that many will seek to adopt the recommendations contained within BS 8580 or oblige their contractors and consultants to do so.

So what does it say? BS 8580 is effectively split into two elements:

- A method by which to conduct a risk assessment
- Specific areas of risk a consultant should consider

The method reduces the risk consultant's focus to five relevant areas of concern:

the practical undertaking of the risk assessment. Inevitably, much is still left to the consultant's discretion, as each site is different containing its own unique quirks, but there are many steers in respect of site-specific circumstances.

So where should BS 8580 feature in the concerns of duty holders and responsible persons? It does not create additional legal duties – as noted above, BS 8580 is not a legal document. However, duty holders must ensure that those they employ to undertake their risk assessments are competent to do so. BS 8580 provides a standard against which competency can now be judged in the event of a prosecution where before no such standard existed. Therefore, duty holders should seek to ensure that their consultants are fully conversant with the guidance contained within BS 8580 and conduct their risk assessments in accordance with its recommendations. If they do, they will have a much stronger defence in the event of a

prosecution to a claim that they had employed a negligent consultant. It is always important to keep in mind that breaches arising from poor quality risk assessments can and often are attributed to the duty holder, and it can be the duty holder who is prosecuted instead of the consultant.

The publication of BS 8580 does not mean that duty holders and responsible people should undertake brand new risk assessments for their premises where such assessments are still in date. However, reviews of current risk assessments and all new assessments should be conducted in accordance with BS 8580. It may be that many consultants are already carrying out risk assessments that reach a sufficient level of competency. However, there are likely to be many that do not, and even better consultants may learn important additional information from BS 8580 which will no doubt improve the quality of their assessments.

So, whilst BS 8580 is a valuable addition to the guidance in respect of water safety, it is not a game-changer. Nevertheless, duty holders and responsible persons who have queries as to the impact of BS 8580 on their health and safety responsibilities can contact Devonshires for specific advice. We can also advise on what you should be looking for when determining the competency of your legionella risk consultant in light of the publication of BS 8580.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk

Corporate manslaughter: The first conviction

One of the areas we get asked about most often is corporate manslaughter. We have now had the first conviction under the Corporate Manslaughter Act 2007. Although the facts of the case are tragic, the court has set down very clear guidance as to how it will treat prosecutions for corporate manslaughter in the future.

Alexander Wright was a 27 year old geologist employed by Cotswold Geotechnical Holdings Ltd (CGH). On 5 September 2008, he was killed whilst at work at a development site near Stroud, Gloucestershire. He was investigating soil conditions in a 3.5 metre deep trench, having been left alone by the company's director to finish off the day's work. He was buried up to his head when soil fell into the trench. One of the owners of the development site tried to free him but more soil fell so quickly that it covered Wright completely. He died of traumatic asphyxiation.

The case against CGH was brought by the Crown Prosecution Service (in conjunction with Gloucestershire Constabulary and the Health and Safety Executive) on the basis that CGH was managed in a way that amounted to a gross breach of the duty of care to Wright. In reaching a guilty verdict, the jury had decided that CGH ignored industry guidance prohibiting staff from entering excavations more than 1.2 metres deep - CGH required their employees to work in unsupported pits 2 to 3.5 metres deep. The jury held that such practices were wholly and unnecessarily dangerous. CGH had also been prosecuted under Sections 2(1) and 33 of the Health and Safety At Work etc Act 1974 (HSWA). However, in order to simplify the proceedings, only the corporate manslaughter charge was fully prosecuted.

Last year, the Sentencing Guidelines Council issued its Definitive Guideline in respect of appropriate fines for corporate manslaughter

convictions. The Definitive Guideline sought to recognise the punitive element required by the seriousness of the offence and the need for the fine to have a real impact on the defendant. The Definitive Guideline stated that in the event death was caused “the appropriate fine will seldom be less than £500,000 and may be measured in millions of pounds.”

CGH offered the following mitigation in respect of the conviction. The company’s director, Peter Eaton, had cancer and was too ill to work. The company’s finances were in a dire condition. CGH employed eight people in total - a fine that put it out of business would also put these people out of work. Justice Field therefore had plenty to consider.

After deliberating, the Judge imposed a fine of £385,000. Due to the state of the company’s finances, he allowed CGH to pay over ten years at a rate of £38,500 per year. The Judge was satisfied the fine was harsh enough to reflect the gravity of the offence and to provide a warning to

The UK’s health and safety legal regime places utmost value on preventative measures, above all in the avoidance of unnecessary deaths (Wright was a young man who died in hideous circumstances). In order for a company to prevent both a tragic death occurring and from inflicting calamitous damage on itself, those in control of companies should keep in mind the following.

When considering a conviction and a fine, the court will focus on the way in which a company is organised and managed, and whether such arrangements fall far below what could reasonably have been expected of the organisation in the circumstances. Senior management are responsible for ensuring their company is not charged with corporate manslaughter, as they have a significant role in the decision-making process and are involved in the actual managing of the company’s activities. A particular focal point will be the extent to which the failures that led to the death were tolerated.

“A particular focal point will be the extent to which the failures that led to the death were tolerated.”

other companies that the courts would take strong action following conviction for a death caused by a company’s negligence. The Judge chose not to impose remedial or publicity orders.

The fine was lower than some expected. However, CGH is a small company – the fine will inevitably cause it vast financial difficulties and may even result in its insolvency. Meanwhile, the widespread publicity of the trial and conviction will have had a significant adverse effect on its reputation. The crime of corporate manslaughter, when committed by a large organisation, will attract penalties of commensurate proportions. Indeed, when a much larger company is convicted, there can be no doubt that the court will impose a fine of millions of pounds. Due to the necessary punitive element, a billion pound company may find it is ordered to pay far more than that. A company with very deep pockets could find its balance sheet severely troubled by the impact of a conviction.

Inevitably, those asking us about corporate manslaughter often have one eye on their own prospective liability. The good news is that only companies can be charged with corporate manslaughter. The bad news is that individuals can be prosecuted in respect of the same death under S.37 of HSWA, for which there are also stringent penalties, including an unlimited fine and a prison sentence of up to two years. Had Eaton been of better health, the enforcing authorities may have decided to proceed against him personally as well as against CGH. The conviction of CGH makes it wholly feasible that Eaton would have been convicted as well as his company, and may have been sent to prison.

Successful convictions against individuals have been and continue to be very difficult to achieve, hence the introduction of corporate manslaughter. A company – particularly a large one – is often more guilty than the individuals within a chain of

command. Nevertheless, a successful corporate conviction is meant to rebound harshly on those within the company. A remedial order imposed against the company is designed to ensure that those running it change their negligent ways. And a publicity order can impose obligations that embarrass those running the company. Managers may feel it is they personally who have been found guilty.

In order to avoid such shame, all organisations should regularly review their company practices to ensure they avoid the kind of systemic malaise that enables a successful conviction for corporate manslaughter. As often with health and safety matters, the stakes could not be higher for all involved.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk



A flue with a view – Recent changes in gas safety guidance

10

The recently issued second edition of Technical Bulletin 008 (TB008) has potentially wide-reaching consequences for Registered Providers (RPs), their tenants and leaseholders. TB008 sets out Gas Safe Register's guidance on how to comply with the Gas Safety (Installation and Use) Regulations 1998 (the Regulations) when inspecting chimney systems during the annual landlord's inspection.

Gas Safe Register is the industry regulator, and so registered engineers are obliged to follow TB008. From an RP's point of view, a failure to follow TB008 is likely to result in gas supplies being switched off where flue runs extend through voids into adjoining properties, along with the increasing risk of prosecution in the event that there is an escape of gas which may cause or increase the risk of death or injury.

TB008 requires that chimney systems have adequate provision for inspection. In new build properties, the new revised Buildings Regulations

Approved Document J (the Revised Building Regulations) states that where the flue is concealed:

- All voids containing such concealed flues should have at least one inspection hatch measuring at least 300mm x 300mm.
- No flue joint within the void should be more than 1.5m distant from the edge of the nearest inspection hatch.
- Where possible, inspection hatches should be located at changes of direction.
- Where this is not possible then bends should be viewable from both directions.

What about existing properties? If access to the chimney system cannot be provided as there are no or insufficient inspection hatches, registered engineers must undertake a risk assessment in a form specified in TB008. This risk assessment initially asks the following questions, amongst others.

- Is it possible to determine the likely route of the whole chimney system?
- Where the chimney system is routed through neighbouring properties or areas, is access available in neighbouring properties to carry out this risk assessment?

If the engineer answers "no" to any of the risk assessment questions, the installation must be classified as either "immediately dangerous" or "at risk" and the appliance using that chimney system switched off. Naturally, if this means switching off a tenant's boiler, RPs will have a number of irate tenants on their hands. TB008 states that if no risk assessment has been undertaken by 31 December 2012, the flue will automatically revert to being considered "at risk" and the appliance must be switched off even if there later prove to be no problems with the flue at all. Where TB008 requires that the appliance be switched off, the person responsible must arrange for the installation of inspection hatches. Until then, the appliance cannot be switched back on. The RP

a surprisingly common problem. Devonshires' Housing Management Team regularly obtains injunctions on behalf of clients to gain access to carry out CP12 inspections to a tenant's own property, even though access is only sought to make sure their own gas installations are safe.

Even more contentious is the fact that RPs may need to enter the property of another tenant in order to install one or more inspection hatches and thereafter to access the premises every year in order to inspect the chimney system.

Where access is not freely given for either purpose, the RP will need to consider whether or not it has any rights to enter that property. It will need to look at that specific tenancy or lease as it may be able to construe such rights. Should the tenant continue to resist, and no specific power of entry is provided for by the tenancy or lease, the RP may have to consider obtaining an injunction to allow access to carry out any necessary works.

"Therefore, numerous circumstances exist in which the RP may have to take action."

11

must undertake works to install the appropriate inspection hatches as soon as possible so that (a) the tenant will be able to use the appliances again and (b) the RP can be sure it meets the deadline of 31 December 2012.

Therefore, RPs need to consider carefully the effect of TB008 on those properties where chimney systems run through voids and adjoining properties. Where those properties are pepper-potted with a mixture of social need and leaseholder properties then the ability to comply with TB008 will require not only ongoing co-operation from residents but also a far greater level of co-ordination in carrying out the annual landlord's inspection.

The work an RP is obliged to undertake may prove disruptive and at the very least will require unsightly hatches being installed within properties. The resident may object to the works, even though it is ultimately for their benefit. This is

RPs are not required to obtain CP12s for a chimney system originating from a leaseholder's property. That said, RPs must also consider their wider health and safety obligations under the Health and Safety at Work etc Act 1974 (HSWA). Whilst the person responsible for the flue may not be the RP, the RP may still have to take all reasonably practicable steps in respect of that flue to safeguard the health and safety of the occupiers for whom it is responsible.

Therefore, numerous circumstances exist in which the RP may have to take action. The extent of the action required depends on the type of resident.

Where the resident is a tenant of the RP, the RP may find it needs to seek access for three separate reasons:

- To undertake the risk assessment required under TB008 by 31 December 2012.
- To install such inspection hatches as are required following the risk assessment.

- To undertake an inspection of the flue annually via those inspection hatches.

Fortunately, the Regulations provide an exception to liability where all reasonable steps were taken to avoid a failure to comply – in other words where the RP sought access but was ultimately denied by the tenant. In most circumstances, the following would count as reasonable:

- Contacting the tenant by letter seeking access to undertake the risk assessment / installation works, stating it is a legal requirement that they provide access for you to undertake the risk assessment and, where necessary, the installation works.
- Visiting the property, and if no access is granted or no response is received, leaving the tenant a notice stating that an attempt was made to complete the gas safety check and provide your contact details.
- Giving the tenant the opportunity to arrange their own appointment.

a court to order an injunction in the RP's favour. Whereas the tenancy between the RP and the tenant provides a basis for seeking access for the purpose of carrying out modifications or repair, no corresponding right exists between the RP and a leaseholder. The RP may therefore find it much harder to obtain an injunction for access against a leaseholder.

Ultimately, RPs may find they have a lot of work to do installing inspection hatches from now until 31 December 2012. If appliances are switched off, tenants will of course be pressuring their landlords to do what has to be done as quickly as possible.

Registered engineers will now comply with TB008. In order to prevent the gas supply being switched off to individual properties, RPs should try and ascertain which elements of their stock may be affected and carry out inspections accordingly. Where it is deemed likely that a property will fail to secure a CP12 as a result of TB008, steps should be taken to carry out the necessary works immediately.

“Ultimately, RPs may find they have a lot of work to do installing inspection hatches from now until 31 December 2012.”

12

- Warning the tenant where access has not been provided that, if need be, you will have no option other than to apply to court for an injunction.

Where the resident is a leaseholder and the RP has no obligation to take action in respect of the flue serving the property but for the RP's wider HSWA obligations, it may wish to seek an injunction to obtain access if it believes the possible risk to health and safety is serious enough and that a failure to do so would constitute a failure to take reasonably practicable action to avert the risk to people for whom it is responsible. In order to provide a suitable basis on which to seek such injunction, the RP would need to take similar action as noted above in respect of tenants. In other words, the RP would need to contact the leaseholder resident to inform them of their position and that failure by that leaseholder to provide access would be a reasonable basis for

Should you require advice on how best to achieve this, please contact Mark London or Nicholas Leigh.

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk

Group structures – Where does responsibility lie?

As Registered Providers (RPs) increasingly end up in group structures, the waters can become very muddy indeed as to where the responsibilities for health and safety compliance lie.

Take for instance a parent RP company that sits atop a group structure containing several RP subsidiaries. The subsidiaries themselves may have numerous premises. Compliance with health and safety law therefore requires a clear understanding of where responsibility for those specific premises lies within that group structure and, more importantly, the extent to which an enforcing authority can prosecute the parent company for a health and safety breach that on the face of it is ultimately the responsibility of the subsidiary company.

We recently acted for a large RP which has a group structure, in which the group head company sits atop several subsidiary RPs. The health and safety breach occurred in premises owned and managed by the subsidiary, but rather than prosecuting the subsidiary as the employer,

place loss-making – the subsidiary may have insufficient funds to finance a large fine on conviction.

4. The parent company may have a higher profile than the subsidiary – this was certainly the case in the matter referred to above. As all organisations are concerned with the impact of reputational damage, a prosecuting authority may use such concerns to pile on the pressure.
5. Prosecuting authorities may find it far more convenient to prosecute the parent company rather than determine its way through the group structure to locate exactly where responsibility for the breach lies.

A prosecuting authority will always be interested in determining who actually called the shots in respect of premises where a health and safety breach took place. An RP should always look at the facts on the ground to determine whether or not a prosecuting authority may seek to pursue

“An RP should always look at the facts on the ground to determine whether or not a prosecuting authority may seek to pursue the parent, the subsidiary or both.”

13

the enforcing authority pursued the corporate head directly.

Prosecuting authorities do this for numerous reasons, including the following:

1. The parent company may be responsible for devising and implementing the health and safety policy, practices and procedures for the group as a whole. As such, the policy, practices and procedures may have been imposed from above, the flaws contained within the system the responsibility of the parent.
2. The parent company may be responsible for ensuring that sufficient resources are allocated to the subsidiaries so that the group health and safety practices and procedures can be implemented.
3. The parent company may be wealthy, whilst the subsidiary in which the breach takes

the parent, the subsidiary or both. If the subsidiary is the direct employer, the parent company may in certain circumstances be construed as the true employer, and that some or all of the employer's responsibilities under health and safety law fall upon the parent company rather than the subsidiary. The stronger the influence the parent has over its subsidiary, the more likely this is to be the case.

A parent company must also keep in mind its governance responsibilities. Where it has set the policy, practices and procedures for the group as a whole – indeed, where the health and safety department for the whole group including the subsidiaries is located within the parent company - and the subsidiary has implemented the regime incorrectly, the group head may be partially at fault for failing to ensure the policy was being followed. The prosecuting authority may construe this as a failure of an employer in respect of the group as a

whole and that subsidiary in particular.

Therefore, in order for a group head to avoid the risk of being prosecuted for a failure at subsidiary level insofar as is reasonably practicable, it is crucial that group heads take an active role in the governance of what is actually going on at the subsidiary level, as failure to do so may prove to be avoidably expensive.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk



The changing regulatory system of the care sector

Care and nursing home service provision for older people continues to progress through a period of significant evolutionary change following the introduction of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

This new regulatory system presents a shift in focus from checking systems and processes to measuring outcomes and people's experience of a service underpinned by the requirement to demonstrate improvements in the quality of care provided. As part of its regulatory duty, the Care Quality Commission (the CQC) has produced guidance for service providers on compliance with the regulations and associated outcomes; the outcomes are what people can expect to experience from using the service.

These changes represent a major challenge as the care home sector has to assimilate and incorporate

the new regulatory systems into practice so as to demonstrate evidence of compliance with the essential standards. In addition, this includes the requirement to integrate the new '*code of practice for health and adult social care on the prevention and control of infections and related guidance*' further to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This new code sets out criteria against which registered care providers will be assessed by the CQC.

The Health and Safety Executive guidance on '*Successful health and safety management*' (HSE:HSG 65) provides a useful management process for reviewing existing health and safety arrangements to ensure they meet the requirements of the new care regulatory system. This process is universally recognised for providing effective and quality driven good health and safety management practice.

HSE:HSG 65 is based on principles of risk assessment and control, prioritisation, safe systems of working, training, continuous improvement and promoting a positive health and safety culture, through policy, organising, planning and implementation, measuring and reviewing performance and auditing. Working through this process will enable the incorporation of both health and safety legislation and the new care regulatory requirements with the ability to demonstrate evidence to meet the essential standards and outcome measures for compliance.

As care providers, there are of course legal reporting and notification duties for health and safety under the '*Reporting of Injuries and Dangerous Occurrences Regulations 1995*' as well as under the new Care Regulations. When combined with other reporting requirements for risk and performance data as part of good risk management control, the sector can face considerable duplication of reporting systems.

It is therefore vital for those responsible for health and safety to work closely with the care management team to review and develop operationally practical and uniform systems that do not add unnecessarily to the administrative burden for care staff.

As formal inspections commence for many, including inspectors for the CQC, the new regulatory system represents something of a learning experience. Hopefully this time of transition will be viewed as a way to make real improvements to quality and safety in care provision, support care service providers and we will not revert back to an ineffective 'tick box' exercise.

For further information please contact:

Karen Howell, Health and Safety Manager at Abbeyfield Society on 01727 857536 or k.howell@abbeyfield.com

Recent Cases – Marble City

15

The case of *Health and Safety Executive v Marble City Ltd* has provided health and safety advisors with an early indication of how courts beyond the first instance view the *Definitive Guideline on Corporate Manslaughter & Health and Safety Offences Causing Death* (Definitive Guideline) in cases where health and safety convictions are secured.

An employee of Marble City Ltd, a stone company, died after he was crushed by a five tonne stack of marble slabs being unloaded in a manner the court of first instance ruled to be in breach of S.2 and S.3 of the Health and Safety at Work etc Act 1974. Marble City was fined £100,000 and ordered to pay £46,564 in Health and Safety Executive (HSE) costs. Two directors of the company were also fined £10,000 each.

The Court of Appeal rejected Marble City's appeal on the basis that the judge at first instance had

given sufficient credit to the company's mitigation and that the fine initially imposed was not excessive. Having pleaded guilty, the Judge gave Marble City the full early plea discount. Therefore, the starting point from which the Judge decided the fine was £150,000.

The Marble City Court of Appeal judgment has received some criticism for failing to establish a clear starting point for sentences. However, the Definitive Guideline states that where a health and safety offence causes death, the appropriate fine will seldom be less than £100,000 and may be measured in hundreds of thousands of pounds or even millions. The judge at first instance would therefore appear to have been acting within the natural boundaries set by the Definitive Guideline.

Perhaps more cause for concern is the weight of the fine when considered against the financial resources of the company. The Definite Guideline

allows for a defendant company to provide the court with financial information so as to determine the effect of, amongst other things, a fine on innocent people employed by the defendant and whether or not the fine will have the effect of putting the defendant out of business.

In the event of a serious health and safety breach, Registered Providers (RPs) are unlikely to be immune from such thinking. Marble City is a small company. To have received such a large fine – a fine that leads to it going out of business - may appear to be a sufficient penalty for a breach that led to a death. For a large RP the scale of the fine would have to be vast to put it out of business, but some organisations may find that a significant fine will still have a material impact.

The Definitive Guideline states that in some circumstances putting the defendant out of business may not be such a bad thing, for instance if it is a cowboy outfit whose poor

massive fine under the Definitive Guideline for having caused that death.

In order to off-set such risks, RPs must ensure they are maintaining sufficient standards of health and safety across their organisation so that, in the event of a death or serious injury, the court will keep any fine to a minimum. The threshold of reasonable practicability accommodates such considerations – as long as you have been meeting that threshold in the first place.

For further information please contact:

Mark London, Partner on 020 7880 4271 or mark.london@devonshires.co.uk

Nicholas Leigh, Solicitor on 020 7880 4397 or nicholas.leigh@devonshires.co.uk

Edited by: Mark London

Head Office: 30 Finsbury Circus, London EC2M 7DT

Further copies: Marketing Department on t: 020 7628 7576, or email info@devonshires.co.uk or via our website at www.devonshires.com

Devonshires has taken all reasonable precautions to ensure that information contained in this document is materially accurate however this document is not intended to be legally comprehensive and therefore no action should be taken on matters covered in this document without taking full legal advice.

standards include a failure to take sufficient health and safety measures. In this regard, the Court is absolutely right.

However, the same fact pattern may lead to a death in some circumstances and injury in others, depending on the luck of both the victim and the employer. The death itself may be incidental to the gravity of the offence. Meanwhile, the reverse burden of proof in health and safety law places pressure on the prosecuted to plead guilty in the best of cases. A matter involving a death is clearly not the best of cases.

Therefore, a company or indeed an RP unlucky that death occurred may find itself caught in a steel trap of having to plead guilty due to the reverse burden of proof only to be hit with a

Legal updates and seminars

Devonshires produce a wide range of briefings and legal updates for clients as well as running comprehensive seminar programmes.

If you would like to receive legal updates and seminar invitations please visit our website on the link below.

<http://www.devonshires.com/join-mailing-list>