

Can legalistic mechanisms such as 'corporate liability' effectively be used to promote organisational safety?

The essay title questions if organisational safety can effectively be promoted by legalistic mechanisms such as corporate liability. At first sight one wants to answer with yes – what reason at all have legalistic mechanisms in this regard if not having a hand in the improvement of safety? But what exactly is needed for this improvement? Does it mean that regulations are adapted, supervision is enhanced or work instruments are changed? And are these requirements finally complied with through mechanisms such as corporate liability? Considering these questions, the author comes up with the conclusion that currently used legalistic mechanisms are only able to promote organisational safety in regards of obvious safety grievances to be eliminated. But this does not imply a change in an organisation's culture what would be the groundwork for a lasting improvement in organisational safety (Waring, (1993) cited in Module I, Unit 6: 6.6.3; Toft and Reynolds, 2005: 85). The author therefore suggests a review of legalistic mechanism and proposes other measures such as periodic audits of cultural change to work towards a safety culture.

The author's argument is hardened through the analysis of two case studies in the light of a f*unctionalist* and *interpretative world view* (Burrell and Morgan (1979), Smircich (1983), Waring, (1992, 1993, 1996a) cited in Module I, Unit 6: 6.3-6.5), the *high-blame* and *no-blame* approach (Hood *et al.*, 1992: 157-158) and the aspects of *general* and *specific organisational learning* raised by Toft and Reynolds (2005: 65-114).

The essay starts with the explanation of the term *corporate liability* in the light of the recommendations given to the Parliament by the Home Office (2005: 6) and the term *organisational safety* regarding its connection to the theory of *safety culture* (Module I, Unit 6: 6.6.1-6.6.3; Taylor, 2010: 2; Schein 2010: 23-33). The work of Taylor (2010) is also used to introduce the idea of cultural assessment that encouraged the author to suggest the above mentioned audits of cultural change as a method to improve organisational safety.

After an explanation of terms and theories, a short overview of the chosen case studies will lead over to an analysis in support of the author's argument. The essay finishes with concluding summary and recommendations for further research and action.

Having outlined the general direction and structure of this essay, the key terminology and theories shall be explained and discussed. The term *Corporate Liability* describes the often discussed question whether an organisation as entity can be made responsible for offences or not. In the UK the discussion peaked in the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA) that came into force in April 2008. While corporate manslaughter was linked to the guilt of gross negligence of a senior individual within the organisation, the Act enables the prosecution of the organisation as entity for a serious incident, if gross failings of the senior management to take reasonable care for the safety of their employees or members of the public can be identified (Home Office, 2005: 6). The CMCHA is to understand as complement to existing health and safety law and regulations that allows legal bodies to implement penalties affecting the corporation instead or in addition of the punishment of individuals within an organisation. The penalties in this context are explained in details by the Sentencing Guidelines Council (2010: 7-9) and identified as to be a fine with no upper limit and / or a publicity order and / or a remedial order. Coming back to the initial question if current legalistic mechanisms can effectively be used to promote organisational safety, the nature of the penalties must be discussed further. The above mentioned sanctions primarily aim to punish and deter, monetarily with the fine and morally with the publicity order which can be seen as a sort of blame. The ability and will for change of a defendant is addressed only rudimentary on saying that " … a remedial order should be considered if it can be made sufficiently specific to be enforceable … " (Sentencing Guidelines Council, 2010: 9) in a case where the defendant did not yet remedy failings that where involved in the offence.

The debate about legalistic measures rises also questions about the nature of *organisational safety*. What does it mean to promote organisational safety by legalistic means? Is it enough to edit regulations and to punish the ones not complying with? To answer these questions it is important to understand the different aspects coming together if talking about 'organisation' and 'safety'. While the latter in this context includes all aspects concerning the health, safety and welfare of persons working within an specific organisation and other persons affected by the organisations activities (Health and Safety at Work etc. Act, 1974: 1), it becomes already more difficult to identify the nature of an organisation, depending if one looks at it from a cultural or a systemic view. Nevertheless the different approaches and aspects are brought together if theorists talk about an *'organisation's safety culture'* which is best described as to

include ” …shared attitudes, values, beliefs and practices concerning the importance of health and safety and the necessity for effective controls.” (IOSH, (1994); Waring (1996a), cited in Module I, Unit 6: 6.6.1).

Interesting regarding the author’s argument are the different levels of organisational hierarchy that have an impact on the safety culture. Taylor (2010: 2) lists the four levels as to be the upper management, the middle management, the supervisors and the workforce. Additionally he outlines the importance of the multi-layer construct introduced by Schein (2010: 23-33), which illustrates that basic assumptions, espoused values and artefacts form altogether an organisation’s beliefs which motivates the behaviour that is finally recognised as an organisation’s (safety) culture. These findings enlighten the complexity of the subject and imply that a cultural change is not possible, if this complexity is not understood and measures do not address the different levels of hierarchy and layers of influencing factors. Taylor (210: 130-167) continues on proposing a way to assess an organisation’s culture by a set of given safety culture characteristics and their different attributes. The degree of presence of these attributes would indicate the strength of each characteristic. A strong characteristic shows that a safety culture is alive in an informal dimension (behaviours), weak characteristics are depicting a gap between the formal dimension (documented expectations, artefacts) and the informal dimension in an organisations safety culture.

Going a step further and linking safety culture with specific world views, the previously explained connections become comprehensible. As cited in Module I, Unit 6: 6.3, Burrell and Morgan (1979) and Smircich (1983) propose two categories of organisational culture: The *functionalist* and the *interpretative world view.* The layers that form these opposite cultures are characterised by Waring, (1992, 1993, 1996a cited in Module I, Unit 6: 6.4-6.5) as to be deterministic, rational and fact-driven in the case of a functionalistic and more holistic, considering the world as to be emergent, dynamic and interacting in the case of an interpretative attitude. A functionalist organisation would therefore try to 'engineer' a safety culture e.g. by controls, pre-defined procedures and strict command structures, while an organisation with an interpretative view of the world would accept the ambiguity of human behaviour and try to support participation, flexibility and common learning (Module I, Unit 6: 6.6.2). Remembering the intricate structure of culture it is likely that an organisation in favour of a functionalist world view does not succeed in changing its safety attitude as it does not respect the very nature of any culture.

Looking again at the author's argument and the comments given on the nature of the penalties currently in use by legal bodies it is obvious that these measures are also based on a functionalist world view. Whether the penalty includes a fine, a publicity order or a remedial order – the punishment remains deterministic, based on the assumption that safety is increased by selective sanctions.

With regards to the following case studies, two further theoretical aspects must be discussed. The *high-blame* and *no-blame approach* as explained by Hood *et al.* (1992: 157-158) and the concept of *general* and *specific organisational learning* as introduced by Toft and Reynolds (2005: 65-114). Both theories are closely connected with the previously discussed subjects. Supporter of the high-blame approach argue that failures will continue to occur if liability is not targeted on decision makers who are in the position to actively reducing risk. This approach implies that the responsibility for failures can clearly be allocated and future failures can be predicted through the intervention of a specific responsible. This perception is obviously influenced by a functionalist world view and can also be observed in the current punishment practices. Although the liability moved away from individuals to the corporation as entity with the enforcement of the CMCHA, the penalties remain very much based on a blaming practice. While organisations with a functionalistic culture probably pursue in the same manner within their organisation, corporations following a more interpretative approach are likely to implement internal measures that promise better success. The claim of the no-blame approach supporters, that blaming practices may create counter-productive reactions such as the concealment of deficiencies and near-misses and an effective improvement of safety can only be achieved if all incentives to hide information about failings are avoided, is therefore an opinion likewise to be found in interpretative structures.

The theory about *general* and *specific learning* introduced by Toft and Reynolds (2005: 65-114) on the other hand describes the factors that influence the general ability of an organisation to learn and the more specific factors that affect the degree to which active learning is realised. Without discussing the different concepts in detail, it is important to take note of Toft and Reynolds conclusions. They name a number of factors that will affect the amount and scope of changes made in an organisations safety culture. They specify as an example the degree of responsibility an organisation feels towards the production of an incident or the degree of surprise an organisation has been subjected to. These and other listed factors allow one common conclusion: All factors imply a bigger amount and scope of changes in organisations

following an interpretative world view. Toft and Reynolds complete their discourse with the suggestion that organisations which are able to implement lessons learnt from disasters are likely to not experience the same disaster again.

To prepare for the introduction and analysis of the case studies, the author wants to summarise the conceptual framework of this essay in a few sentences. It was explained that legalistic mechanism allow to prosecute corporations as entity, nevertheless the penalties in use aim to blame and punish in a punctual way and do not encourage a cultural change towards increased safety. As it was shown, the attitude of organisations to learn and improve depends on their world views and it could be seen that organisations following an interpretative world view are likely to not become the subject of similar failures again, independent of the punishment imposed on them. On the other hand organisations sharing a functionalist world view will not be able to change their culture, likewise independent of the punishment imposed on them. This actually implies, that an improvement of safety cannot be achieved by legalistic mechanism, but only by the organisation itself. These findings shall be verified with the following case studies and will lead to the author's conclusion and recommendations.

The first case study is a research paper written by Justin J. Waring (2005) who analysed the point of view of medical physicians towards adverse incident reporting in health care on paying special attention to the factors causing barriers of participation. He conducted semi-structured interviews with hospital personnel to learn about cultural issues that build significant barriers to medical reporting. He concludes his work with the suggestion to move away from a 'culture of blame' towards a 'culture of medicine' to promote effective incident reporting. The author uses Warings findings in the following to illustrate the thoughts expressed with the conceptual framework.

The second case study analyses the prosecution history of UK based corporations convicted of breaches against the Health & Safety At Work Act 1974. The Health & Safety Executive (2001) provides a list of 1,687 breaches of the act that were brought to trial since 1999. The HSE publishes as well three organisations convicted for offences against the CMCHA. Additionally there can be seen that 401 prosecution cases involving different acts and regulations resulted from a fatality. The author of this essay focussed on organisations that were convicted for offences against the mentioned act and had a close look on organisations and juristic bodies that were prosecuted more than one time. Of the over 1,500 different defendants at least 35

were prosecuted for breaches in several cases. Out of these defendants, the prosecution history of the Tata Steel UK Limited and the UK Coal Mining Limited are in the following analysed in more details and used to support the authors argument.

Starting the analysis with Waring's research paper, the first point to be mentioned is the remarkable notice of the interviewed doctors that they see failures as inevitable and believe that the occurrence of errors in medical work cannot be managed. They therefore generally think that incident reporting is meaningless as errors anyway will occur. This approach does by all means reflect a functionalist world view as it accepts a certain phenomenon as given based on a simple cause-effect calculation. If the cause cannot be controlled with regulations and clearly written procedures, the effect will continue to appear and be accepted as given fact. This point of view is hardened in a different way through an expressed understanding of the medical physicians that incident reporting may help managers and decision makers to engage in and improve the regulation of medical quality. With this understanding the interviewed personnel shows again its believe in determinism. Another characteristic of a functionalist culture can be found in the doctor's disconnected view of the world. They seem not to be able to imagine incident reporting as an instrument for organisational learning, but only as instrument to come up with more regulations. It was explained earlier in this essay that a cause and effect based functionalist world view goes hand in hand with a high-blame culture. This connection can also be found in Waring's paper in an interesting way: the interviewees indicate their fear from external as well as from internal blame. While they mention 'the public', 'the press' and 'the Trust' as sources of external blame, they indicate their fear regarding internal blame more ambiguous as the danger to be questioned i.e. by senior colleagues regarding their individual competence and professionalism. These answers indicate that the fear of internal blame is more scaring for the medical physicians. They cannot clearly relate their fear as they are able to do for external blame. The answers remain an expression of a general uneasiness and are named by one respondent as to be based on the 'old culture' within the organisation, meaning that conventional customs and hierarchies are dictating an individual's career. These findings support the author's argument. Waring proves that deterministic measures such as the current legalistic mechanisms in use do not fit a deterministic system. They instead support a blaming culture which does in fact lead to the concealment of information and hinders organisational learning. It was further identified that fear particularly exists of internal blaming.

If blaming shall be avoided and general and specific learning fostered to increase safety, an organisation's culture has to be addressed. Warings work therefore points out the significance of collegiality and the importance of internal or self-regulation to move away from a 'culture of blame' towards a 'culture of medicine' (with which he addresses the ethos of the genre). The suggestion of the author of this essay to adapt legalistic mechanisms towards supporting measures to initiate a change in culture respectively to address the 'ethos' of a specific organisation or branch reflects this insights.

Regarding the second case study, the general figures have already been introduced. While these details do not give a meaningful implication, the conviction register of two specific organisations that were prosecuted in several cases yet give. The Tata Steel UK Limited was ten times prosecuted between 2010 and 2014 for offences conducted between 2006 and 2012. Three of the ten offences were prosecuted based on breaches of regulations other than the Health & Safety At Work Act 1974. Analysing the different offence and hearing dates it is obvious that the organisation was not able to improve safety in the aftermath of an incident, regardless if the conviction already took place or not. In 2006 the company faced a fatal accident and a fatality within 4 months, in 2007 an explosion caused a remarkable potential for accident. In 2008 Tata Steel UK suffered three accidents and a near miss. In 2009 two more accidents occurred within 2 months. The hearings of this cases took place between 2010 and 2012. It could be assumed, as no improvement appeared so far, remarkable efforts to avoid further accidents would have been taken after the organisation was charged a total fine of over £ 420,000, but a further incident causing major injuries occurred in late 2012 for which the organisation was prosecuted in the beginning of 2014 with another £ 25,000. While there did not yet occur another accident since 2012, it cannot be assumed that the organisation would change its safety attitude based on this additional penalty.

The UK Coal Mining Limited offers a prosecution history alike. The company was convicted for breaches of the Health & Safety At Work Act 1974 in four and of breaches regarding another regulations in one case. The organisation was found guilty for three fatal accidents and one fatality between June 2006 and November 2007. Another fatality occurred only two months later in 2008 and an accident causing severe injuries in 2009. One year later, UK Coal Mining was responsible for the ignition of gas underground which can be seen as a potential for accident and was therefore prosecuted as well. The last prosecution case resulting from the investigation of a fatality is reported in 2011. The hearings for these cases took place between

2011 and 2013 and the organisation was charged with a total fine of £ 1,900,000. The concerning fact that an organisation faces three fatalities over a period of five years can be seen as an inability or unwillingness to change the safety attitude. Again the prosecution history shows that the applied penalties did not promote increased organisational safety.

Yet an interesting point to add is the completely different picture the organisations draw with their public presentation (Tata Steel Europe Limited, 2014; UK Coal Mining Limited, undated). The Tata Steel Group stresses their 'zero harm' approach and claims that they implemented a group-wide H&S policy in 2011. The analysis of their annual and corporate citizenship reports over the last few years in fact shows a decrease of fatalities and of the lost time injury frequency rate which they use as another key performance indicator for Health and Safety. Regarding their UK based group members it can be analysed with the help of the published corporate responsibility reports that particularly the main steel producer Corus took significant effort to reduce health and safety risks and is promoting a safety culture since 2003 with a remarkable decrease the accident rates. The comparison of the different data shows an aspect that was not considered up to now: The importance of localisation as a dimension of organisational culture (Module I, Unit 6: 6.3). Regarding the global Tata Steel group it can clearly be seen that different levels of safety understanding were alive and still are. The relatively late establishment of a group-wide Health & Safety policy in 2011 can be a hint that the group became aware of that fact and tries now to implement a common understanding of safety issues throughout the group.

Analysing the UK Coal Mining's organisational culture and safety approach not as much data as for Tata Steel can be found. Still the company claims as well to follow a 'zero harm' approach and provides details about their 'safety way' they aim to follow on the basis of 12 principles which include all steps from the development of a policy to the monitoring, audit and review of the principles. While the Tata Steel group can prove significant improvement of safety with decreased accident figures, UK Coal Mining does not provide any other evidence of a safety culture approach than their own commitment. A comparison of the published values and beliefs shows that the Tata Steel group tends to a more interpretative world view as UK Coal Mining. While the latter seems to focus on deterministic instruments to build a safety culture the former appears to follow a more holistic approach stressing to value diversity, openness and transparent communication. But whether the organisation follows a functionalist or an interpretative approach, there cannot be seen any direct improvement of safety resulting from

the conviction that took place. While one organisation can prove a progressing implementation of a safety culture by decreasing accident rates, the other does not provide any clear sign of improved organisational safety based on their published safety commitment. Regardless of their commitments both organisations still have to show that they are able to avoid breaches of Health and Safety legislations long-term.

To conclude this essay, the findings shall be summarised in the following. The author has discussed the complexity of an organisation's (safety) culture and has shown that cultural change cannot be fostered by deterministic means. It was explained that a functionalist world view is likely to go hand in hand with a high-blame culture that hinders organisational learning which is needed to improve organisational safety. On debating the current legalistic mechanisms in the UK it was claimed that they follow themselves a deterministic approach and are therefore unlikely to promote effectively organisational safety. The evidence for this claim was given by two case studies. The first, a research paper by Waring (2005) analysing the cultural barriers regarding incident reporting was used to show that legalistic mechanisms in fact support a blaming culture. The second case study involving the analysis of organisations that were prosecuted in the UK for breaches against Health and Safety legislation has shown, that a change in an organisations safety attitude does not stand in direct correlation with convictions and penalties put on them. A change rather seems to appear based on an organisation's self-motivation. Regarding this findings it was argued that the organisation following a more interpretative world view is able to prove a real improvement with figures, while the organisation showing a functionalist behaviour lacks to give evidence for the sincerity of their commitment. The author uses this insights to suggest a new legalistic way to better engage in the critical process of an organisation's cultural change. Legalistic bodies should start to better observe the prosecution history of organisations and enforce an assessment of the defenders safety culture. How this can be done was introduced earlier in this essay by using Taylors theory of cultural assessment. He proposes a set of balanced means such as questionnaires, interviews, the observation of behaviour and discussion groups to gather the needed information. This instruments could be used for an initial cultural assessment to identify objectives and measures for improvement as well as to monitor the progress of the cultural change by the means of periodical audits.

Nevertheless further research regarding the presented ideas has to take place. It must be analysed in more details which factors motivate prosecuted and not prosecuted organisations to initiate a cultural change. It must be thought about the duty of legal bodies, governments, industrial branches and associations to find a balanced break down of responsibility to support organisations with poor safety records. And it must finally be tested if the proposed actions would bring the expected results. The author is convicted that further research in this area will enrich the discussion and help to find new ways to effectively promote organisational safety with legalistic mechanisms.

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