# University of Southampton

Faculty of Social Science

**An empirical and theoretical analysis of the investigation and punishment processes of corporate offending in the UK, 2008-2016**

DOI: https://doi.org/10.5258/SOTON/D2799

by

**[Cem Özdemir]**

ORCID ID [https://orcid.org/0000-0003-0515-0529]

Thesis for the degree of Doctor of Philosophy

[September -2023]

# University of Southampton

## Abstract

Faculty of Social Sciences
Sociology, Social Science and Criminology

Doctor of Philosophy

An empirical and theoretical analysis of the investigation and punishment processes of corporate offending in the UK, 2008-2016.

by
Cem Özdemir

Existing studies on workplace corporate offending are limited to major issues such as punishment and definition rather than workplace deaths resulting from corporate violence. Corporate and safety crimes have been invisible in the criminal justice system and are missing from the criminology literature. This PhD thesis will help to reify corporate and safety crimes and contribute to the literature by applying a mixed methodology and several qualitative methods (documentary analysis, case studies, vignettes and supportive semi-structured interviews) and statistical analysis as a quantitative method. The thesis aims to answer three research questions: 1) How have UK government policy and legislation against corporate crime been implemented in practice since 2008? 2)Why can some corporate violence that resulted in deaths be seen as safety crime while others cannot? 3)What are the factors and roles of agencies that influence the prosecution process and the final decision?

Statistical analysis was used to make an original contribution to the literature by examining the investigation and punishment processes of 759 work-related deaths (WRDs) and categorising them into five types (covering nine years: 2008-2016) to help answer the research questions. Approximately 46 per cent of all cases were punished under health-and-safety laws and regulations between these dates while 31.4 per cent of cases were not prosecuted or not punished. The CPS and court preferred to bring a charge of gross negligence manslaughter in only 13 cases and a charge of corporate manslaughter in around 3 per cent of all cases. 16 per cent of cases resulted in accidental death due to a variety of factors including the policing of corporate crime.

Two case studies and 14 crime vignettes were employed to analyse the characteristics of these five investigation results. Criminal justice systems have taken a lenient regulatory approach, which can be seen in accidental death verdicts, coroner's reports, the low conviction rate and low fines to act as a deterrent. Three important approaches within the prosecution and punishment processes are effectively part of the problematic picture of corporate crime, namely obtaining satisfactory evidence, the agencies' approach and role (such as deciding public interest in a case and prioritising deaths in particular industry sectors) and the seriousness of negligence. This analysis provides more precise knowledge than previously available about the implementation of justice in the UK from 2008 to 2016. Notably, it reifies safety crime within the criminal justice system and in the scholarly literature, determining the reasons and factors behind non-convicted and convicted cases by analysing empirical data gained through published and unpublished documents and supporting them with interviews, which are currently yet to be done in this way. This research identified the characteristics of each type of investigation and punishment process and helped to show how agencies' role and policy, the structure of the law, the roles of third-party actors and other factors came to define a case as a crime (safety crime) or an accident (not crime).

# *Table of Contents*

# *Table of Tables*

# *Table of Figures*

# *Research Thesis: Declaration of Authorship*

Print name: Cem Özdemir

Title of thesis: An empirical and theoretical analysis of the investigation and punishment processes of corporate offending in the UK, 2008-2016.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signature: ..... Date:26/09/2023

# *Acknowledgements*

I would like to dedicate my dissertation to those who have recently passed away due to the earthquake in Turkey and to those who died in the workplace in the UK.

Jenny, thank you for all your support and feedback; you and Rod taught me so many things, not only related to completing my PhD but also about the culture of British academia. I appreciate your efforts to push me to keep deadlines and finish my work on time. Rod, thank you for your crystal-clear approach. I much appreciate your invaluable feedback. I would not have finished this work without Jenny's and your guidance.

My wife, Deniz, I can say without exaggeration that I would not have finished this study without your support and understanding. Please accept my apologies that my work often meant I couldn't spend enough time with you. And my lovely little monster, Ali Ozgun, many thanks for your energy and never-ending laughter. As a family, it was so difficult to endure this period, not only because of my heavy workload but also because of Covid 19. Now we can do everything.

I would like to say thank you to many people I met in academic circles and who contributed to my progress. I am very glad to have got to know Dr Fatsis Lambros, Pamela Ugwudike and John Boswell.

William Peskett, thank you for your editorial advice and patience. Jonathan Lightfoot, thank you for all your advice about layout and help.

Dr Yigit Sumbul, your language skills have always been invaluable, and your friendship has been very important for me. Thanks a lot.

My father, Nevzat Özdemir, thank you for your encouragement, love and support. I think I have done more than half of this study for you and in thanks to you. My mom and brother, thank you for your support as well.

I would like to say thank you to the Graduate School, especially I am very grateful to Jane Parsons and Claire Caffrey for all that you have done for me on this journey.

Finally, to my friends: Dr Osman Karaca, you have been always with me whenever I needed to ask something; Burak Kucukgoz, Deniz Emek Saitoglu and Ismail Can Kurtuk, Selman Gultekin, I am very grateful to know you, you were always with me in my difficult time, and all my office colleagues, Michele, Dr Gopala Sasie Rekha and others, thank you for sharing your time, your kindness and your support.

# *Abbreviations*

BBC..... British Broadcasting Corporation

CCA..... Centre for Corporate Accountability

CJS..... Criminal Justice System

CMCH..... Corporate Manslaughter and Corporate Homicide Act

CotP ..... Crimes of the Powerful

CPS..... Crown Prosecution Service

DPA ..... Deferred Prosecution Agreements

FAB..... Fresh Air Base

FAI..... Fatal Accident Inquiry

FoI ..... Freedom of Information

GNM..... Gross Negligence Manslaughter

ILO..... International Labour Organization

IPP..... Investigation and Punishment Process

HSE..... Health and Safety Executive

HSW Act..... Health and Safety at Work Act

MoD ..... Ministry of Defence

PFD..... Prevention of Future Death

RIDDOR ..... Reporting of Injuries, Diseases and Dangerous

SHP..... Safety and Health Practitioners

SCPT ..... Situational Crime Prevention Theory

WRDs ..... Work-Related Deaths

# Chapter 1 Introduction

## 1.1 Interest and aims

This chapter introduces the aims and core topics of this thesis. It describes the significance of the research, the research aims, and presents the methods of the thesis and the research questions.

### 1.1.1 The significance of the thesis

David Whyte (2020) gives a clear and crucial message to humanity with his thought-provoking book entitled '*Kill the Corporation before it Kills Us*'. Indeed, many people die every year due to the wrongful actions of corporations or as a result of the capitalist production process in the UK

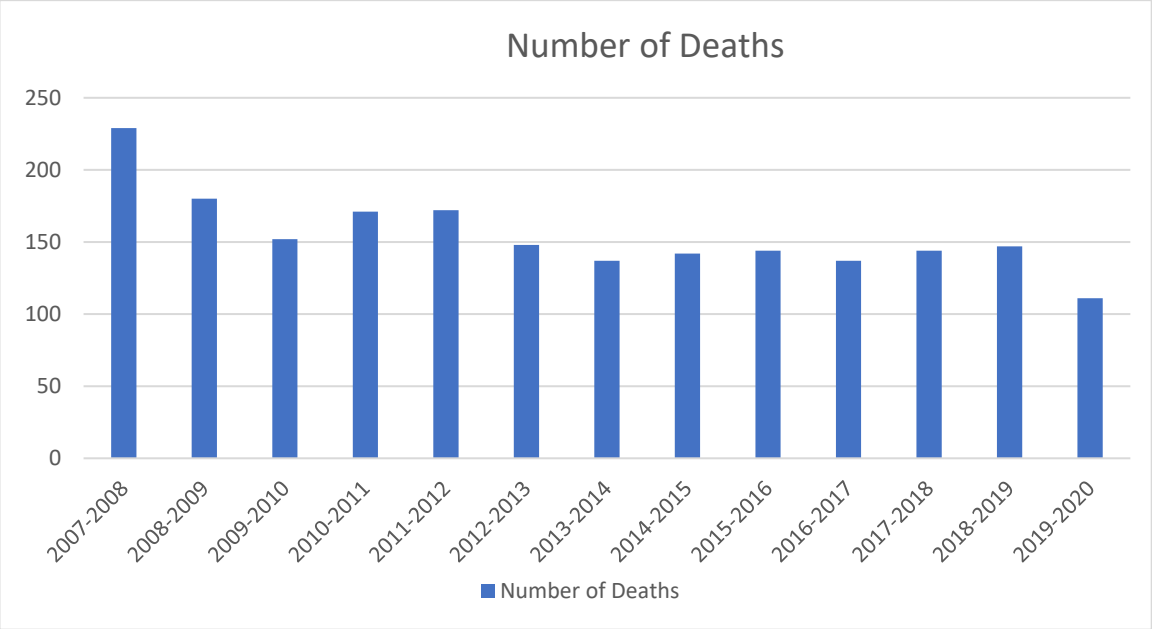



*Figure 1-1 The number of deaths in the workplace*

(Whyte, 2020; Carrabiean et al., 2014; Almond and Colover, 2012; Pearce and Tombs, 1998). Even considering only the cases reported as workplace deaths (WRDs) to the Health and Safety Executive (HSE), the severity of the devastation can be evidently comprehended (see ***Figure 1.1***[1]).

There have been studies on workplace corporate offending, but it can be argued that these are limited by the information that can be found between the lines in criminological studies (see for further discussion Tombs, 2007). Braithwaite (2000) argues that criminologists generally tend to

[1] The figure represents deaths of members of the public, employees, the self-employed and employers (Health and Safety Executive, 2020a).

research street crimes in the context of prevention, punishment, and the police-court-prison web rather than considering corporate crimes. Indeed, the scope of criminology barely relates to workplace corporate offending (Tombs, 2007). Importantly, there has been a lack of reliable and useful official research data on the processes of investigating and punishing safety and corporate crimes (Tombs and Whyte, 2007).

Almost two decades have passed since Braithwaite (2000) and Tombs (2007) highlighted this gap. Recently, some valuable research has been done (Hébert, Bittle and Tombs, 2019; Tombs, 2018; Almond and Colover, 2012). Hébert, Bittle and Tombs (2019, p.3) emphasise a particular gap stating that 'there is none [no study] examining the effects of its [the Corporate Manslaughter and Homicide Act's] enforcement, particularly in terms of how findings of guilt help to frame understandings of corporate killing.'

This empirical reality indicates that criminology has given relatively little attention to safety crime, as a type of corporate crime, and has derived relatively little understanding of the punishment and investigation process. The examination of safety crimes as a type of corporate crime will help to increase our criminological understanding by providing insights to explain the following issues:

1. A broad picture of dealing with safety crime in the UK (see Chapter 5).
2. The characteristics of case have led to the acceptance of a wrongful act as a corporate manslaughter by the criminal justice system (see Chapter 6).
3. Under what conditions can a manager or owner of a company be found not guilty even if there are opposite indicators of deaths caused by corporate violations (see Chapter 7).
4. The characteristics of cases and vignettes in which the investigation process was successful and unsuccessful (see Chapters 5 and 8).

Importantly, this thesis contributes to the existing literature in the following ways:

- Analysing the prosecution and punishment processes from the records of a broad range of workplace deaths. This analysis provides more precise knowledge than previously available about the implementation of justice in the UK from 2008 to 2017. Notably, it reifies safety crime as a type of corporate crime within the criminal justice system and in the literature.
- Determining the reasons and factors behind non-convicted and convicted cases by analysing empirical data gained through published and unpublished documents and supporting them with interviews, which are currently yet to be done in this way. This analysis helps provide comprehensive and recent explanations for the central problems, these being the low number of punished companies and some wrongful activities that have not been evaluated as safety crimes.

- Addressing the roles of institutions and the factors in the prosecution and punishment process of workplace deaths through case studies, vignettes and statistical analysis. Such analyses could better explain governments' response through a wider lens. The investigation of relevant cases using a criminological approach provides useful insights to clarify the role of different agencies, such as the HSE, the police and the courts.

These issues ensure that this research makes a unique contribution to the literature in that it enables us to organise obvious and hidden facts about the investigation and punishment process of corporate violence that has led to employees' deaths. It seeks to reveal the importance of factors and the agencies' roles in the prosecution process by analysing various documents and supporting semi-structured interviews with people who have knowledge and experience in this area. The analysis of the cases, and the statistical analysis of agencies' response to workers' deaths, provide insights to understand the government's response to corporate crimes with a broader perspective. Furthermore, a significant contribution of the thesis is that it provides comparatively precise and reliable data.

### 1.1.2 Methodological approach

Mixed methods were applied to examine safety crime; documentary analysis, statistical analysis, case studies and vignettes. In addition to this, it was supported by semi-structured interviews. The mixed methodology allowed triangulation in this research. Statistical analysis as a quantitative method was adopted to augment the qualitative research methods- documentary analysis, case studies, crime vignettes and supportive semi-structured interviews.

The statistical analysis identifies five main types of investigation and punishment results of WRDs. One of these types (cases prosecuted under corporate manslaughter law: guilty and not guilty decision of corporate manslaughter) was examined through two case studies while the other types of result were examined using the crime vignettes and statistical analysis. The crucial factors which had an influence on the judgement, the actions taken by governmental institutions and their roles, the features of the cases under the law and the influences of third-party factors (for example, lawyers, campaigners and professionals) were analysed through the case studies and crime vignettes. Several sources (HSE records, court hearings, coroner's reports, sheriff's reports and mass and local media output) used in the case studies, crime vignettes and statistical analysis were examined through documentary analysis.

### 1.1.3 Research questions and objectives

There have been many valuable studies on safety-related and corporate crimes (Galvin, 2020; Hébert, Bittle and Tombs, 2019; Tombs, 2018; Simpson, 2013; Almond and Colover, 2012; Croall, 2001; Pearce and Tombs, 1998; Braithwaite, 1984; Sutherland, 1983) that enable us to shape theoretical and empirical hypotheses and helped to design the research for this thesis(see Literature Review).

This thesis seeks to investigate examples of work-related corporate offending that has caused deaths in the UK. In doing so, it requires a thorough understanding of the investigation and punishment processes (IPP) of work-related corporate offending. It will allow the clarification of the IPP of safety crime.

The second aim is to identify the factors and the roles of crime-related agencies (e.g., the Health and Safety Executive (HSE), the Crown Prosecution Service (CPS), the Police) in successful and unsuccessful prosecutions.

This thesis seeks to answer the following research questions:

1) How have UK government policy and legislation against corporate crime been implemented in practice since 2008?

2) Why can some corporate violence that resulted in deaths be seen as safety crime while others cannot?

3) What are the factors and roles of agencies that influence the prosecution process and the final decision?

The study identifies five types of IPP considered by the police and non-police agencies for work-related deaths gained through the statistical analysis, case studies and vignettes (see Chapters 5, 6, 7 and 8).

The first type presents two different decisions of corporate manslaughter: guilty and not guilty verdicts. The first decision (guilty verdict) concerns a successful prosecution under the Corporate Manslaughter and Corporate Homicide Act (CMCH Act), under which corporate bodies were penalised. In the second instance, police detained a manager suspected of being responsible for deaths, even though the court had found the company not guilty of corporate manslaughter. This case represents a not guilty decision of corporate manslaughter within cases under corporate manslaughter law. These two instances were examined through case studies (see Chapters 6 and 7).

The following categories were examined through statistical analysis and vignettes (see Chapters 5 and 8). The second category is composed of 'no information' and 'no further information on court process' cases. The third type of case indicates that the company was not prosecuted and punished under the CMCH Act but was investigated and punished or not (cases went unpunished) under health and safety laws, even though the result of the action was the same, the case having led to deaths at work. The fourth type of case involves gross negligence manslaughter. The last group consists of inquest process of workplace deaths which the coroners or coroner courts deemed to be an accident including lawful, unlawful killing, open, narrative verdicts, misadventure orders. These categories are identified in my statistical analysis and further explored in case studies and crime vignettes (see Chapter 8).

It is necessary to introduce the motivation of this research; to list the main empirical and theoretical problems related to corporate crime; and to consider the insights that helped to design this PhD thesis.

## 1.2 Context

Even though corporations' power and their potential criminal activities have increased (Barak, 2017; Punch, 1996), corporate offenders have generally been ignored by political powers as compared with conventional criminals, which is evident in the lenient punishments handed down, the limited resources provided for crime-fighting agencies and insufficient legislation policy (Barak, 2017; Slyke and Bales, 2012; Slapper and Tombs, 1999). Tombs and Whyte (2007, p.69) highlight this invisibility in the following way: 'At the broadest level, safety crimes remain socially, politically and academically invisible in ways which mirror the invisibility of corporate crimes in general.'

The differences between street-level and corporate offences can be observed through punishment and prosecution practices. However, the damage derived from corporate violations and damage more generally to society is the same as the harm derived from street crimes (Mascini, 2016). Furthermore, the punishments for such offences tend to be lenient even though the crimes committed by the powerful (corporations, managers, local and central governments, and business people who run their own businesses) can be severe and dangerous (Ruggiero, 2015). This problematic image related to corporate crime and (specifically) workplace deaths can be understood by focusing on central issues related to corporate crime phenomena such as the definition, treatment, and seriousness of corporate crime.

*The labelling of corporate and safety crimes*

Considering fundamental discussions in criminology, this research covers (i) descriptions of workplace deaths in the media and official documents, (ii) the seriousness of workplace deaths, and (iii) the evaluation of workplace deaths within the UK criminal justice system. The evaluation of themes has broadly helped to indicate the main scope of the research and how fatal workplace injuries have been labelled as safety crime as a subset of corporate crime in the literature and in practice.

### 1.2.1 Description of safety and corporate crimes in the media and official documents

The actions of corporations and individuals that lead to various harms are not generally described as crime within the criminal justice system (see Michalowski, 2015; Pearce and Tombs, 1998). Pearce and Tombs (1998) argue that the media and official staff generally describe workplace deaths as being caused by an accident rather than their cause constituting a serious crime. This attitude may be viewed as legitimising the criminal activities of companies (Pearce and Tombs, 1998). Tombs and Whyte (2007) argue that the whole attitude to workplace deaths is problematic; changing the description of WRDs by labelling them 'industrial killing' or 'violence' could bring a totally different legal, political and social approach to WRDs. The illegal activities of corporations, managers and company owners cause many workplace deaths, so these accidents can be called crimes (Pearce and Tombs, 1998). The differences between a crime and an accident as well as governmental agencies' response to this distinction regarding the given punishment and the conceptualisation of such cases involving corporations are some of the central issues of this thesis.

Simpson and Weisburd (2009) introduce a crucial discussion on the definition of corporate crime and the question of which acts by companies, employees or both should be involved in the concept of crime. This issue informs the dilemma of whether the acts of companies (or individuals) should be defined as illegal or wrongful.

#### 1.2.1.1 Illegal or wrongful activities

Levi and Lord (2017) argue that wrongful activities, regardless of they are being criminal activities, can be seen as a subject of criminology. Michalowski (2015) responds to this view and criticises the consideration of crime on the basis of only certain types of harm. It is essential to understand this discussion for the clarification of the corporate crime phenomenon. To solve this problem, Croall (2001, p.14) proposes to 'restrict the category to all violations of the law but to include non-criminal violations. This solution enables the prosecution and punishment of corporations' illicit activities in the criminal justice system' (Croall, 2001). The present thesis argues that companies' activities, which lead to death and other types of harm, should be considered serious crimes

rather than wrongful or accidental incidents. The definitions and seriousness of workplace deaths as perceived by the criminal justice system help us comprehend this difference thoroughly.

#### 1.2.1.2 Definitions of corporate and safety crimes

A definition of safety crime is necessary for this thesis and for any discussion of the findings. Considering the definition of safety crime as a type of corporate crime, the evaluation should initially start with conceptualising of white-collar and corporate crime, and then safety crimes can be discussed.

Existing white-collar crime definitions have the deficiency that they prevent all corporations' and individuals' wrongful and illegal actions from being covered comprehensively. Sutherland (1949) is the first researcher to focus on white-collar crime. He states that people who have respectful status in society and high-profile positions break the law and regulations related to work. This definition covers a broad range of criminal activities and criminals, yet not enough to include the broader actions of small and less powerful corporations and individuals. One of the reasons for this is that the above definition is limited to people of a certain high social status (Croall, 2001). However, small and medium-sized companies are also responsible for criminal activities (Croall, 2001). Punch (1996) argues that a broad range of individuals and companies, as well as ordinary people, can act unlawfully in the financial world and in industry.

Quinney's (1964) conceptual approach to white-collar crime – that an offence can be considered a white-collar offence if the act of the offender is related to work – is partly acceptable in this thesis. Otherwise, it also covers occupational crimes committed by individuals to gain personal benefit while doing their job (Trevino, 2019); such crimes are out of the scope of this thesis.

These definitions may not highlight a wrongful action which refers to taking low-level responsibility by an individual or company. Some corporate crimes occur because of irresponsible actions or failure to take high-level responsibility in workers' favour (rather than the company's favour) and to provide adequate safety conditions at work.

This thesis argues that a definition of safety crime as a subset of corporate crime must include two critical issues:

- Work-related activities of organisations or individuals (regardless of their socio-economic status and political or economic power) that cause various types of harm (physical, psychological, economic or social); and
- Actions resulting from not taking a high level of responsibility to prevent harm to people (regardless of the scope of the law).

This thesis conceptualises some workplace deaths caused by corporations' wrongful actions as safety crime as a type of corporate crime. Two main postulates support this choice: firstly, that workplace deaths occur due to law-breaking or omission by corporations which are defined legally; secondly, the occurrence of the crime is related to a production process – in other words, employees died when companies gained profit. This thesis also names the wrongful act and behaviour of companies and individuals that led to deaths as 'safety crime' as a type of corporate crime (see for further info, the Literature Review), like used before in the context of Tombs and Whyte' study 'Safety crimes' (Tombs and Whyte, 2007).

### 1.2.2 The seriousness of workplace (safety) crimes as a type of corporate crime

The above discussion illustrates one of the central dilemmas of this thesis – that is, what kind of wrongful or illegal behaviours or activities are accepted as serious crime. Almond and Colover (2012) state that the criminal justice system has not treated corporate crimes in the same way under criminal law due to their perception (corporate crime is not seen as a serious crime). Safety crimes may not be committed by an actor who has a guilty mind: thus, such actions seem 'technical rather than moral in nature', and companies are accused of negligence rather than in proportion to the caused outcomes (Almond and Colover, 2012, p.998). The perpetrators' activities are mostly perceived as a result of economic production than as crimes (Almond and Colover, 2012).

The perception of the seriousness of safety crime and the distinction between accident and crime can be observed in two ways: Firstly, by investigating police agencies such as the courts, police and Crown Prosecution Service' approach to workplace deaths to examine which cases concluded with conviction, not-guilty and accidental-death decisions. In this thesis, the term 'non-police agency' refers to an agency that does not have the power to arrest or pass sentence, while a 'police agency' is one with the power to arrest, pass sentence and return a verdict. The low number of prosecuted and punished cases may be seen as an indicator of their perception. For instance, in the period 2008-2009, 104 workers died according to HSE records. Despite this, the courts punished only two of these cases for corporate manslaughter, and agencies evaluated 42 cases in total under health and safety acts and regulations in the period.

Secondly, the cases that concluded with verdicts of not guilty, non-investigated cases and 'accidental death' verdicts provide insights to explain what kinds of workplace death are accidental rather than serious crimes. Agencies' attention that shows how they respond to workplace deaths can be understood in this way. To illustrate this, crime-related agencies failed to

prosecute 50 out of 107 cases and concluded 13 cases with accidental death verdicts in the 2010-2011 period. On the other hand, the criminal justice system punished a remarkable number of companies, managers and owners.

The number of punished and unpunished cases indicates an inconsistency in that some workplace deaths were punished; in contrast, some illicit activities went unpunished. This contrast can be understood through an examination of most given court decisions and non-prosecuted cases. The evaluation of governmental and non-governmental agencies' responses to corporate crime helps to conceptualise corporate offending phenomena.

### 1.2.3 The evaluation of workplace deaths within the criminal justice system.

Here, the intriguing question arises as to how the criminal justice system and governments reacted to these deaths. There was no criminal legislation that identified wrongful acts as corporate manslaughter in the UK until as recently as 2007. The UK governmental agencies passed a new law – the Corporate Manslaughter and Corporate Homicide Act – in that year and defined some corporate wrongdoings as corporate manslaughter, such as CAV Aerospace Ltd after 2007. This act covers the deaths of members of the public and workers, and some governmental institutions became responsible bodies for corporate manslaughter via this act. However, this attempt did not solve all the problems. Many non-investigated cases and some wrongful acts by corporations are still not seen as crimes even when corporations' activities lead to deaths.

Agencies still evaluated work-related corporate offending under different laws and regulations such as the Health and Safety Work Act 1974 (HSWAct) and common law. The wrongdoings of companies have not always been evaluated under criminal law but managed by regulations. A few corporations have been prosecuted for corporate manslaughter, even though there have been a huge number of workplace deaths (Tombs, 2018). The number of cases are expected to be higher than they are. Benson Kennedy and Logan (2016) argue that the real number of corporate crimes is much higher than reported as long as breaking regulations is counted as a corporate offence. I provide examples below of the different implementation of legislation on corporate violations. The investigation and punishment process of work-related corporate offending can be displayed by the following 'decision tree' (***Figure 1.2***).

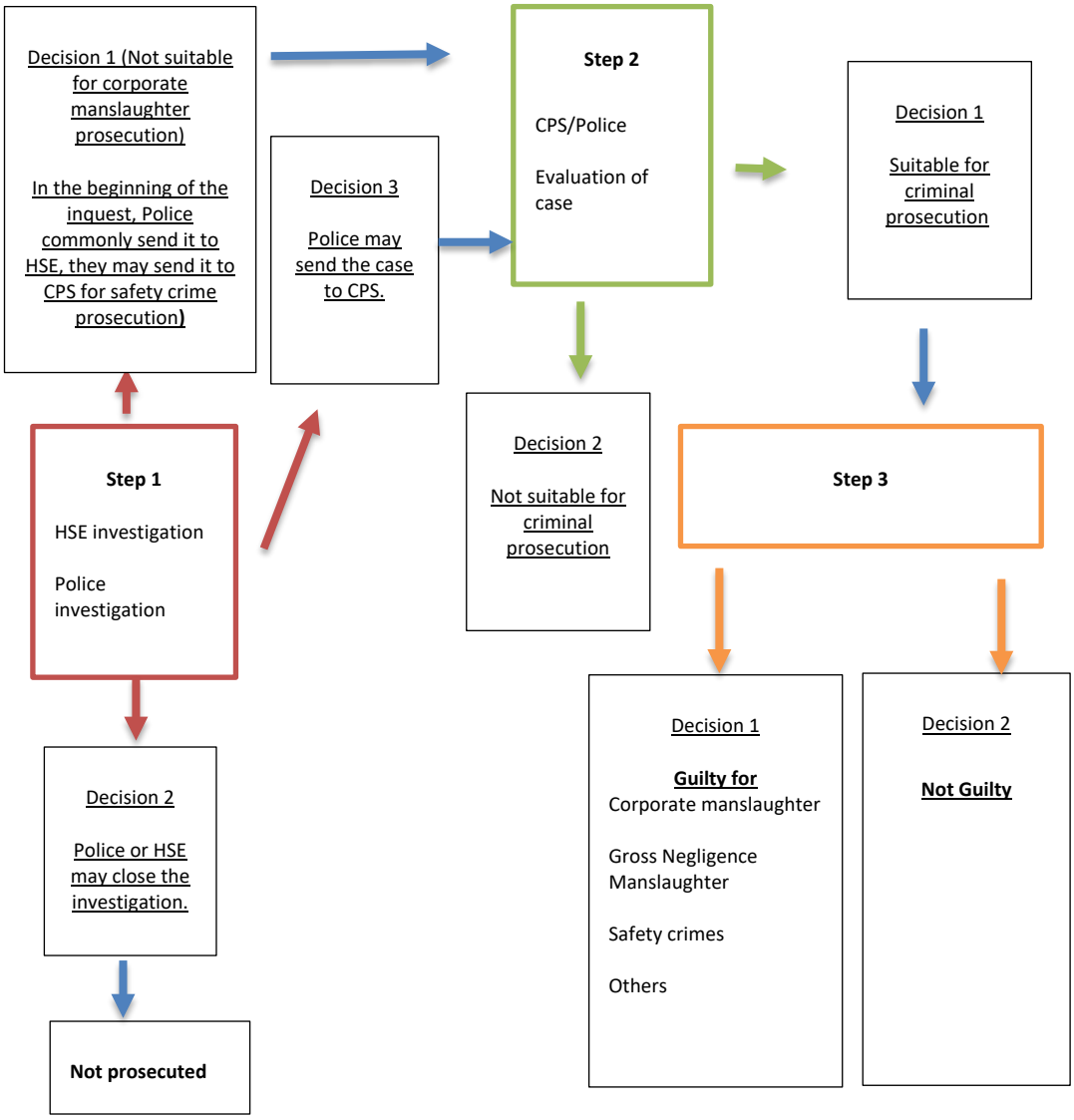



*Figure 1-2 Decision tree for the prosecution and punishment process of WRDs*

The most common results of the prosecution process are guilty, not guilty, and not investigated cases under the acts and regulations. Apart from this investigation process of WRDs presented in ***Figure 1.2***, there is a different inquest process that refers to coroners and coroner courts' decisions, accidental death verdicts. This type of inquest process was analysed through Chapters 5 and 8. There is a complex investigation and inquest process. Cases are covered by more than one law, and more than one agency – the HSE, CPS, police and DPP – prosecute cases. This has led to complexity in terms of investigative authority and the consideration of cases to decide the scope of the relevant law and regulation. It is worth paying criminological attention to corporate crime policing and the instances of different punishments. Simpson (2013) emphasises that, since

Sutherland (1939[2]) proposed the concept of 'white-collar crime', such debatable issues as the implementation of laws and the characteristics of criminals as well as which kinds of legal action cover the problems revolving around these crimes have still not been resolved. Safety crimes cannot be discussed regardless of these issues.

## 1.3 Outline of the thesis

The overall structure of the thesis consists of nine chapters, including this introductory chapter. The remainder of the thesis is structured as follows:

*Chapter 2* explains the legal context of this thesis. It broadly analyses the Corporate Manslaughter and Corporate Homicide Act (CHMC Act).

*Chapter 3* reviews the existing literature on corporate and safety crime. It provides an overview of the conceptual debates on multiple definitions and the terms of safety offences. It also discusses central problems related to corporate offending phenomena involving WRDs in the criminology literature, such as the punishment of criminal activities, safety crime policing strategies and the effectiveness of legislation on workplace corporate violence. This chapter helps to understand primary theoretical and empirical issues on safety crime such as the small number of corporate manslaughter convictions. Additionally, I have analysed the strengths and weaknesses of existing studies to contextualise the contribution of this thesis to the criminology literature. The chapter includes a critical theoretical perspective: the crimes of the powerful within critical criminology. In this chapter, the key arguments of critical criminologists were discussed. The scholars of critical criminology provide a critical-theoretical basis to define main problematic issues.

*Chapter 4* outlines the mixed methodology and methods used in this thesis. This chapter is divided into four main parts: data collection, data analysis, ethical consideration and challenges. The qualitative case study, vignette approaches, statistics and documentary analysis are explained. In this chapter, the researcher identifies the justification for choosing the methods used in the study and for selecting cases and vignettes. Ethical considerations are discussed after providing the conceptual framework of the research. The potential limitations of the study are identified at the end of this chapter.

*Chapter 5* indicates findings gathered from documents and the statistical analysis of fatal workplace injuries. I have made a statistical analysis of workplace deaths in the period 2008-2016.

[2] Simpson (2013) refers an early study of Sutherland (see, Sutherland, E. H. (1939). *The white collar criminal.* Philadelphia, PA: Presidential address delivered to the American Sociological and Economic Societies).

I draw up a general view of actions against corporate violations in the UK. Statistical analysis of the records indicates the different inquest and punishment processes of corporate violation. This chapter reports the categorisation of more than 759 WRD investigations and court results. This analysis provides valuable insights into the agencies' roles and gives a comprehensive view of applied justice on corporate offending. Notably, the chapter answers Research Question 1 and helps to answer Research Questions 2 and 3. Also provided are the inclusion criteria for cases and vignettes.

*Chapters 6 and 7* deal with two cases and the findings of the fieldwork. They identify how the characteristics of work-related corporate offending result in some being seen as corporate manslaughter and some not. These sections provide background information for each case. They set out the findings of the fieldwork, which focused on the investigative process of corporate wrongdoing. These chapters help to identify the ideal types of successful and unsuccessful prosecutions, highlighting the participants' experiences and similar and different features of cases.

*Chapter 8* examines four different types of investigation and punishment processes through 14 vignettes and identifies the characteristics of these different results by analysing official documents and mass and local media output.

The thesis concludes with *Chapter 9, Discussion and Conclusions*, which draws together notable findings and debatable issues, and indicates failures and conformity of theories and legislation practices. Briefly, the concepts related to critical criminology, the policing of safety crime and conceptualising of safety and corporate crimes have enabled the reasons and factors behind the problematic legislation policy considering various prosecution processes to be described in the light of the findings. Finally, there is a review of the findings' potential to direct future research in this area.

### 1.3.1 Summary of key findings

Statistical and documentary analysis show that the HSE and police investigate most workers' deaths (approximately 81 per cent of all cases). Many investigated cases (almost 63 percent of investigated cases) were punished in 2008-2016. However, this punishment took place under regulations and health and safety law, not the CMCH Act (around 90 percent of punished cases). It is likely that the HSE and police play a crucial and positive role in securing justice in workplace deaths, while the CPS and courts are not inclined to consider cases as corporate manslaughter. The term, secure justice, is used to refer only to a punished case (or cases) in this thesis.

The level of severity, gross negligence (the level of negligence should be enough to convince jury) in companies' acts (determined by agencies and law) and a high level of attention from police and non-police agencies are three critical factors in determining a case as corporate manslaughter. However, the seriousness of any negligence is evaluated mostly by the CPS and judge, not by the HSE or police because of the boundaries of authority determined by the Act. The level of attention from agencies changes between successful and unsuccessful cases. It becomes a crucial factor in the collection of evidence and in the final decision. Therefore, this study argues that the legislation against corporate manslaughter is vague, and several factors affect the low number of successful prosecutions. These factors also mean that some worker deaths are considered to be corporate manslaughter while others are not. Some of these factors can be explained by the following:

- Only 3 per cent of cases resulted in corporate manslaughter. 16 per cent of cases resulted in accidental death verdicts including open, unlawful, misadventure and narrative verdicts) while 19 per cent of all cases were out of the agencies' area of interest, and they did not send to court or punish 12.4 per cent of all cases which failed to get agencies' attention due to their policies or limited resources, or they could not be evaluated as potential crimes due to the conditions of the accident scene, or the lack of witnesses or evidence.
- Strict guidelines, determined in the CMCH Act, for handing down guilty verdicts for corporate manslaughter.

The role of agencies is the most pivotal factor in the final decision after satisfactory evidence. The CPS plays central role in considering the right type of criminal law for a case (such as considering the public interest and the seriousness of negligence in a corporate manslaughter prosecution). The HSE has taken a more central role than other agencies before and after the case regarding the investigation and collection of evidence even though its policy is to use limited time and resources effectively in deciding a case for further investigation. The role of the court (the judge and jury) is an important factor in making the final decision and applying punishment. The police's role is limited. The police are usually guided by the HSE, whose staff accompany the police at all stages, specifically while conducting interviews and collecting evidence in WRD cases.

# Chapter 2 Legal Context

## 2.1 Introduction

In this short chapter, I discuss corporate manslaughter law under five titles: the need for new legislation, the process of enactment, corporate criminal liability, individual liability and public interest. It provides legal context to understand debatable issues in the literature review. This analysis may help to understand how Corporate Manslaughter and Corporate Homicide (CMCH) Act applied in practice and which parts of the Act is problematic.

Corporations, business owners, and managers are punished under the realm of safety crimes as determined by the 1974 Health and Safety at Work Act (Tombs, 2007). However, a critical number of cases involving workplace deaths have not been prosecuted (see Chapter 5 for more information), and relevant inquest processes have been quite complicated (Hébert, Bittle and Tombs, 2019; Tombs, 2018). The unsuccessful prosecution of big companies with intricate structures and the low number of inquests required new legislation for corporate manslaughter (Tombs, 2018).

There have been studies on how corporate violence generated by corporations has been punished in the criminal justice system and central problems related to new legislation. I have focused on five main issues: (i) *the reasons for new legislation,* (ii) *the process of new legislation,* (iii) *corporate criminal liability,* (iv) *individual liability and (v) public interest*.

### 2.2 The need for new legislation

The Corporate Manslaughter and Corporate Homicide Act (CMCH Act) plays a relatively crucial role in the implementation of justice in the UK. The preparation process of new law presents a broad narrative of corporate manslaughter; therefore, there is a need to analyse the new law and challenges to the prosecution of illegal activities committed by companies on previous and current laws and regulations.

In health and safety acts and regulations, companies' wrongful activities are not evaluated as corporate manslaughter and serious crime; they are generally regarded to have broken regulations and punishment is relatively lenient. Even though the Health and Safety at Work Act 1974 allows the prosecution of specific individuals (owner, manager, and workers of the company) and companies, and these actors can face prison sentence in the courts (Health and

Safety at Work etc. Act 1974), the number of these cases is very low and generally these convicted companies are small (see, Chapter 5).

For the first time, the CMCH Act enabled the investigation of a company or an organisation for corporate manslaughter where deaths or fatal injuries occurred due to the gross negligence of companies and/or organisations (Whyte, 2018; Slapper, 2010). Importantly, the fundamental reason for enacting a new Act was to increase the number of successful prosecutions particularly involving big companies and/or complicated organisations.

Before the CMCH Act, there were very few prosecutions despite the fact that there were adverse disasters – for instance, the Herald of Free Enterprise (almost 200 passengers and crew were killed when the ferry sank in 1984) and the Southall rail crash (seven people died and many were injured in this 1997 train crash) (Tombs, 2018). The increasing public demand for a new law provided momentum to make improvements. For instance, Doyle and Scott (2016) argue that several cases, such as the Clapham rail disaster (1988) and the Piper Alpha oil rig explosion (1988), led to public demand to force the introduction of a new law. Furthermore, Parsons (2018) evaluates the Southall train crash (1997) as a compelling factor that led to government enacting a new law allowing large corporations to be held legally responsible for illegal activities. In this case, the Great Western Train Company was not punished for causing the Southall train crash due to the fact that it was a big corporation, which made it difficult to pinpoint and punish the responsible person (Parsons, 2018). In other words, identification doctrine was not a viable solution to secure justice in cases involving big corporations and/or complicated organisations (Parsons, 2018; Tombs, 2018; Whyte, 2018).

As some other researchers have stated, Parsons (2018, p.305) highlights the aim of the new Act that "to enable the courts to get away from the identification doctrine with its emphasis on the directing mind of the corporation being grossly negligent to an offence that would impose direct personal liability on a corporation where there has been a gross management failure which was the cause of a person's death".

However, the CMCH Act has yet to translate this into practice even though there has been one instance of successful prosecution in the CAV Aerospace Ltd case, in which there were no problems determining the persons responsible for actions leading to a worker's death (Tombs, 2018). Additionally, in one of the unsuccessful cases – the MNS Mining case (see Chapter 7) – regardless of the company's size, the police arrested a mining manager as a responsible person, but the jury ruled them not guilty (Morris, 2013). These examples show that one should remain sceptical about the efficiency of new law. The enactment process, scope and implementation of the new law may provide more insights to analyse the performance of the regulatory strategy.

## 2.3 The process of enactment

The CMCH Act was passed 13 years after it was initially discussed in the Law Commission. Some claim that one of the reasons behind for delay and gaining in favour of companies in law was that powerful groups, such as the Confederation of British Industry and Institute of Directors lobbied the government not to pass the act (Gobert, 2008; Whyte, 2018). In law literature, Gobert (2008) argues that the commencement of the act relied on a 1994 Law Commission Report that referred to corporate manslaughters as well as the 2000 Home Office consultation document related to private prosecutions of corporate manslaughter. The relationship between policy and corporation may negatively affect legislation on corporate crimes. Braithwaite (1984, p. 299) noted that 'An official of the Association of the British Pharmaceutical Manufacturing Industry told me that many British government regulations were written in their offices'. A similar relationship became a factor in the process of enactment of the CMCH Act. Some scholars, both in criminology and law, examined this issue. For instance, Gobert (2008) claims that a shadow political relationship led to the failure of the act. These allegations refer to the problematic enactment process of the CMCH Act.

On the other hand, a law scholar, Roper (2018), proposes a different explanation: this period reflected effective and careful processes to collect recommendations and guidance. Roper (2018) approaches the act positively; she states that the expected purpose of the new law was realistic, and it combined other regulations. Crucial discussions have scrutinised work-related corporate offending and considered whether the new act's characteristics provide an effective solution to corporate manslaughter and other issues, such as criminal liability and the seriousness of corporate crime. Corporate and individual liability are discussed in the following sections.

## 2.4 Corporate criminal liability

Under this heading, I discuss the challenges of the prosecution and punishment processes and developments on new law regarding the punishment of responsible actors.

The courts' fundamental challenge in complicated prosecutions is identifying a responsible actor for the wrongdoing (Whyte, 2018). Whyte (2018) indicates that although the CMCH Act was regarded as a fair law against advantaged groups (huge companies), the act absolves stakeholders, owners and some senior managers from the crime. A relevant clause in the act supports this argument:

> No individual liability.
>
> (1) An individual cannot be guilty of aiding, abetting, counselling or procuring the commission of an offence of corporate manslaughter.

> (2) An individual cannot be guilty of aiding, abetting, counselling or procuring, or being art and part in, the commission of an offence of corporate homicide (Corporate Manslaughter and Corporate Homicide Act 2007).

Roper (2018) claims that the criminal justice system can charge individuals regardless of their status or power, and charge companies depending on their economic conditions. However, this can be observed in only a few judicial decisions where companies were charged with massive fines on a par with the gravity of the underlying crime.

### 2.4.1 Corporate autonomy

The CMCH Act does not affect corporate autonomy in terms of preventing corporate crimes, in contrast; legal authorities could design corporate autonomy to discourage corporate harm in the act (Tombs, 2018; Whyte, 2018). Pearce and Tombs (1998) approached workplace corporate crimes from the angle of corporate autonomy and organisational structure. The lack of bureaucratic hierarchies decreases accountability, while increasing the number of taken risks (Pearce and Tombs, 1998). In the case of a workplace corporate crime, the responsibility can never be attributed to anybody specific due to the haphazard designation of roles for safety and accident prevention procedures. The researchers observed that 'the problems of organisational autonomy and decentralisation can also be highlighted by examining the relationship between top-level corporate guidelines –which give strong rhetorical support for safety and regulatory compliance – and policies at site or plant level' (Pearce and Tombs, 1998, p. 164).

Critics suggest that the CMCH Act does not consider corporate autonomy as a factor in corporate crimes (Whyte, 2018). Indeed, some researchers have argued that the act failed to investigate large and powerful organisations for corporate manslaughter (Hébert, Bittle and Tombs, 2019; Tombs, 2018; Whyte, 2018).

### 2.4.2 Stakeholders as irresponsible actors

Additionally, legislators ignored the responsibilities of stakeholders in terms of corporate manslaughter (Whyte, 2018). The CMCH Act can be evaluated as an improvement for senior managers as it absolves them from blame for stakeholders' activities, and it seems to protect stakeholders against corporate manslaughter (Whyte, 2018). Thus, the CMCH Act is similar to common law in practice despite its original intention to fight corporate manslaughter (Tombs, 2018; Gobert, 2008). Overall, Whyte (2018) concludes that the act does not intend to restrict corporations' power. One of the reasons behind this unsuccessful initiative was that the law does not enforce corporate autonomy (Whyte, 2018).

## 2.5 Individual liability

Hébert, Bittle and Tombs (2019) find that crime-related agencies send only a few companies to court on charges of corporate manslaughter. They argue that the CMCH Act protects individuals from charges by bringing 'corporate entity through a guilty plea'. The researchers assert that the corporate veil protects owners and stakeholders against a corporate manslaughter conviction. As illustrated in three cases where courts charged any responsible actors despite the prosecution process indicating the existence of a possible corporate wrongdoing (Hébert, Bittle and Tombs, 2019). Parsons (2018) has arrived at a similar conclusion. The author examined cases between 2008 and 2018, in which 24 small and medium-sized corporations were convicted. In agreement with Parsons, Tombs (2018) assesses eight cases concluded before 2009 that only included small companies. However, Roper (2018) takes a different approach and argues that the reason why most SMEs were successfully prosecuted under the CMCH Act was that the majority of work-related deaths had occurred in small- or medium-sized companies, which tend to have a relatively greater incidence of undesirable working conditions, such as a lack of professional checks for health and safety requirements.

Individual liability may create injustice in punishing the companies. Corporations tend to increase economic benefits, and this organisational behaviour can be observed in individuals. The individuals represent companies, and they represent the company's economic policy; therefore, they feel the necessity to obey owners or stakeholders, and this necessity may lead to them ignoring some rules (Pearce and Tombs, 1998). Braithwaite (1984) argued that individuals – managers and executives – cannot act regardless of company aims and policies. These people can be evaluated based on this premise. Braithwaite (1984) proposed that corporations can be charged instead of individuals in the courts. It provides an effective crime-fighting strategy, and individual responsibility should be arranged by the corporation rather than the courts (Braithwaite, 1984). On the other hand, senior managers and top-level executives should account to the court (Braithwaite, 1984). These explanations show that effective punishments of corporate violation in the criminal justice system are not merely individual liability.

Tombs (2018) provide an account of individual liability problem and the implementation of the law. The researcher (2018, p.489) describes the main problem of old law against big organisations needs to be overcome by referring the characteristic of existed successful prosecutions which all were against small companies that "; the legal test of identification required identifying a company's acts and omissions with those of one or more controlling minds, corporate guilt being dependent on the prove-able guilt of one or more senior individuals (usually, directors)". In the next section I discuss what new law brought to figure out the 'identification doctrine'.

### 2.5.1 The visible problem: senior management test to overcome identification doctrine problem

The reason behind the low number of successful prosecutions was the difficulty in finding responsible actors within large companies and complicated organisations, as the old law focused on finding individuals responsible for gross negligence rather than proving corporations' wrongdoing (Parsons, 2018; Tombs, 2018; Whyte, 2018). The new law (CMCH Act) brought 'senior management test' to resolve the identification doctrine problem.

Punishing corporate offences may become a difficult process due to the difficulties in finding the responsible person and proving unlawful action (Forti and Visconti, 2020; Ruggiero, 2015). The obscuring of corporate violence becomes complicated regarding reifying the connection between the corporation's activities and its destructive consequences that lead to an unsuccessful inquiry (Tombs and Whyte, 2015). Workplace incidents, such as deaths and losses, can be evaluated as the most useful example of a type of corporate crime considering the access to more reliable sources (Forti and Visconti, 2020). Understanding problems related to the punishment of corporate offenders provides insights into the analysis of findings and cases in this thesis.

The policymakers proposed a solution to figure out this punishmet problem. It is necessary to discuss the novelty of the CMCH Act, senior management test, in understanding to what extent it can be evaluated as an important improvement.

The relevant clause in the act is:

> […] senior management, in relation to an organisation, means the persons who play significant roles in (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or (ii) the actual managing or organising of the whole or a substantial part of those activities. (Corporate Manslaughter and Corporate Homicide Act, 2007).

The main concerns (a problematic enactment process, protecting stakeholders, limited corporate liability and excluding individual liability) have been discussed above. There has been another criticism related to the CMCH Act, senior management test.

Parsons (2018, p.307) states one of these concerns related to senior management regarding the implementation of it that '(…) the contribution of middle managers and below must not render the role of senior managers insubstantial, otherwise the corporate manslaughter offence will not be made out'. The researcher (2018, p.307) warns that the old problem can again be occur, and companies may not be liable 'by delegating health and safety to middle managers'.

Some argue that legislators did not adequately identify the concept of the senior manager or clearly defined in the act (Hébert, Bittle and Tombs, 2019; Tombs, 2018). Furthermore, the Act did

not include precise information about how agencies or companies can identify responsible persons in a company. This may lead to some confusion in practice. Roper illustrates this issue by giving an example.

> In order to come to a decision to dismiss the charge, the Honourable Mr Justice Coulson gave consideration as to who the senior management of the Trust was on the facts. He suggested that the prosecution did not necessarily have to name the relevant senior managers involved in the breach, rather it should be required to identify the 'tier' of management that it considers to be the lowest level of senior management within the organisation that is culpable for the offence. (2018, p. 58)

Nevertheless, it is likely finding the actor responsible for gross negligence within company and punishing the company is not difficult especially for the cases small companies involve (for instance: number of punished cases) or it may not a factor on the high number of non-convicted cases (at least for the cases involving small and medium size companies, see Chapter 5, 7 and 8). There might be other reasons to explain this situation. The small or big organisation can be charged with corporate manslaughter, but 'a substantial contribution by senior management to the gross breach of duty is required' (Parsons, 2018, p.305). Parsons (2018, p.305) raises a commonly shared concern: 'Has this requirement made the offence ineffective against large corporations?

The crime agencies (courts) applied the new law for only small or medium-sized enterprises (SMEs) (Hébert, Bittle and Tombs, 2019; Tombs, 2018; King and Lord, 2018). Tombs (2018, p.498) criticises this picture by saying that

> So while it is inaccurate to say that the new law has changed nothing, it remains the case that its overwhelming targets have thus far been micro or small organizations with 'hands-on' directors who are clearly identifiable as the controlling mind of the company and who could have been prosecuted (and convicted) under existing common law.

Tombs (2018) argues that it is easy to identify the person responsible for a wrongful act in a small company using the OLL Ltd corporate manslaughter case as an example. In his paper, he used the term 'corporate veil' to criticise the CMCH Act as it protects individuals from corporate manslaughter.[3] Tombs (2018, p.500) defines the term as 'an effect of corporate personhood and limited liability'. Furthermore, Hébert, Bittle and Tombs demonstrate the problem of the corporate veil in the Pyranha Moulding[4] case that

[3] Clause 18 states 'An individual cannot be guilty of aiding, abetting, counselling or procuring the commission of an offence of corporate manslaughter' (Corporate Manslaughter and Corporate Homicide Act 2007).

[4] In 2010, Alan Catterall was killed at work and the company was fined £200,000 even though the case concluded with a verdict of not guilty for corporate manslaughter (Guardian, 2015).

> The judge addresses a company director and clearly reveals the contradiction of the corporate veil: The company may only act through its directors and senior officers. The company's failure was also your failure – although the full responsibility does not fall on your shoulders. Rightly, you were not charged with gross negligence manslaughter. I fully accept that you and [the victim] were friends and that you were also devastated by the loss. (2019, p. 15)

Parsons (2018) states that there was no initiative to launch a criminal investigation to explore the possibility of a corporate manslaughter prosecution against the Royal Borough of Kensington and Chelsea Council and the Kensington and Chelsea Tenant Management Organisation. Parsons (2018) questions whether the CHMC Act provides a solution concerning the 'senior management test' or not.

Similarly, Roper (2018) focuses on the Grenfell Tower fire. She argues that the new act did not solve complex cases involving economically significant and influential organisations. She concludes that the investigators should be well-qualified and keen to reconsider the corporate criminality.

The discussions about senior management test provide critical clues about the characteristics of successful cases composed of mostly small companies and the low number of convicted corporate criminals. However, there are other reasons to explain the low number of cases and lenient punishments in that the characteristics of offenders (companies or organisations) are deemed less harmful, and they are seen as not strong enough to cope with a prison sentence (Galvin, 2020).

The fundamental difference between the CMCH Act and old law is the determination of criminal activities by companies or organisations through senior management test for wrongful actions causing deaths even though there is only one kind of case (CAV Aerospace) which senior management test was applied it (Tombs, 2018). I argue that new law has not made any difference in practice for many cases involving small companies and/or hands-on businesses. Some argue that the Act cannot be evaluated in terms of performance on this issue yet due to insufficient knowledge and experience (Hébert, Bittle and Tombs, 2019; Tombs, 2018).

There has been another condition to punish companies, public interest. The next section briefly discusses this factor.

### 2.6 Public interest

Public interest is a controversial factor in the enforcement of criminal corporate law. Tombs and Whyte (2007) conceptualise public interest as a 'protective state response' to safety and corporate crimes. However, the CPS (Crown Prosecution Service, 2018) perceives it as an important factor 'in securing corporate accountability for serious offending'. Police agencies pay

close attention to public interest in deciding whether or not to make a further criminal investigation. This may contribute to a problematic picture of the criminal justice system, involving low numbers of criminal investigations of corporate manslaughter. I will return this issue in the Chapter 9.

## 2.7 Conclusion

The common law and HSW Act allow the prosecution of individuals and focus on finding the responsible person for negligence (contrary to CMCH Act). It led to difficulty in punishing larger companies and/or complicated cases. Furthermore, these acts and regulations have created injustice can be observed through lenient punishment and a low number of successful prosecutions of powerful organisations and companies. To overcome this problem, governments launched a new Act, CMCH Act. However, it is broadly discussed in the literature (Hébert, Bittle and Tombs, 2019; Tombs, 2018; Parsons, 2018; Whyte, 2018) that the CMCH Act has not covered the expectations even after a decade because of the problematic process of enforcement, weak corporate liability and relevantly senior management test raised several concerns about it.

There have been many corporate actions causing deaths that the criminal justice system has not seriously or fairly evaluated. This is a phenomenon that can be traced by implementing the CMCH Act, common law and health and safety regulations and that is the aim of the rest of this thesis. The next step is to review the criminology literature on the different ways in which safety and corporate crime have been conceptualised and to identify the problems which it addresses.

# Chapter 3 Literature Review

## 3.1 Introduction

This chapter is an account of a review of the criminology literature and identifies the most relevant discussions for this thesis topic. Studies of corporate crimes have generally been conducted by criminologists, law scholars, political science scholars and sociologists (Punch, 1996). The chapter's primary purpose is to assess the studies of corporate crime in the context of criminology, which is relevant to safety crimes. Staying within the confines of the criminology literature was difficult due to the diffuse nature of the topic, nonetheless I tried to evaluate predominantly criminological studies. There are a few exceptions directly relevant to my thesis. Importantly, theoretical discussion has been overwhelmingly done around the studies of critical criminologists (such as David Whyte, Frank Pearce, R. J. Michalowski, Steve Box and Steve Tombs) in this chapter.

The second aim is to answer the question: 'How have work-related corporate offending phenomena been evaluated in the literature on the criminal justice system?'

Even though many studies in the various disciplines have been proposed to describe the central problems related to corporate crimes, the literature review has mainly focused on five major themes emerging in the criminology literature. These themes are: (i) corporate violence and harm, (ii) conceptualising safety crime as a subset of corporate crime, (iii) the characteristics of treatment on corporate crime and corporate crime policing strategies, (iv) the seriousness of the corporate crime, and (v) the importance of agencies.

The illicit activities of corporations may be understood as a 'social and ethical problem' (Punch, 1996, p. 39). The conceptualising corporate crime is much debated and addresses various issues: definition, causation, punishment and prevention (Simpson, 2013; Levi and Lord, 2017). These issues have not been solved though they have been addressed (see Levi and Lord, 2017; Simpson, 2013; Croall, 2001; Pearce and Tombs, 1998; Braithwaite, 1984). One possible reason is that corporate crime components, such as corporate offenders, laws, crime agencies and the government's responses to crime, are evaluated differently in the literature and in practice.

### 3.1.1 The level of criminological interest in safety and corporate crimes

In the recent literature, relatively little attention has been paid to work-related deaths or to analysing the Corporate Manslaughter and Corporate Homicide Act (CMCH Act) 2007 (see Chapter

1). After the CMCH Act was enacted, scholars in different academic disciplines increasingly paid more attention to corporate offending and safety crimes (see Hébert, Bittle and Tombs, 2019; Tombs, 2018; Whyte, 2018; Roper, 2018; Parsons, 2018; Arewa et al., 2018; Tombs and Whyte, 2015; Almond, 2009).

These explanations show that there has been a relatively low-level criminological understanding (compared to street-level crimes) of workplace corporate offending in terms of punishment and applied legislation due to the limited number of criminological studies on relevant issues. Thus, the examination of safety crimes by focusing on the corporate harm, its punishment and treatment, the role of agencies (police, Health and Safety Executive (HSE), Crown Prosecution Service (CPS) and courts) and, problems in the prosecution and punishment processes can help to increase the coverage of the criminology literature.

### 3.1.2 Safety crimes

*Safety crimes* (Tombs and Whyte, 2007), a study worth particular attention here, should be considered in terms of its contribution to the literature and in relation to this current thesis. The most obvious difference is that the data and information analysed in Tombs and Whyte's study (2007) belong to before 2007 (1995-2006) while the scope of this present work is after April 2008. Additionally, I have categorised all types of investigation and prosecution of WRDs (see Chapter 5) and analysed these different types through case studies and vignettes which differ from the study of Tombs and Whyte (2007). In this way, I help to reify safety crime as a subset of corporate crime in the UK. This can be evaluated as an important contribution to the criminology literature.

Further comparison is made in the table.

*Table 3-1 Comparison of 'Safety crimes' and this thesis.*

| | 'Safety crimes' | this thesis |
|---|---|---|
| **General Themes** | Agencies and governments' role and policy.<br><br>HSWA, Factories Act and criminal laws (before 2006).<br><br>Historical analysis of law enforcement.<br><br>Punishment and regulatory theories.<br><br>Fatal and non-fatal injuries in which big companies were involved.<br><br>The relationship between capitalism and policy.<br><br>Invisibility of corporate and safety crimes. | Regulatory (policing) theories.<br><br>Investigative and punishment types and process of WRDs.<br><br>Health and safety acts and CMCH Act.<br><br>Response by each type of agency: convicted corporate manslaughter cases, accidental death decisions, gross negligence manslaughter, 'no information' cases and cases investigated under health-and-safety regulation. |
| **Methodology** | Multiple case study: eight atypical convicted and non-convicted cases.<br><br>A general analysis of statistics covering investigated, non-investigated, convicted, and non-convicted figures of fatal and non-fatal injuries.<br><br>Historical and theoretical analysis. | Two case studies<br><br>Vignettes: illustrative crime vignettes.<br><br>A comprehensive and detail statistical analysis.<br><br>Interview. |
| **Data** | Media output and official documents.<br><br>The records of HSE and ILO (1996-2005). | HSE records covering eight years (2008-2016).<br><br>Court hearings, Coroner's reports, Sheriff's FAI reports.<br><br>Mass and local media output.<br><br>Fieldwork. |

Tombs and Whyte (2007, p.135) asked a similar research question to this thesis: 'How has the criminal law in England and Wales developed a form of corporate liability for manslaughter?' The researchers looked for reasons behind the weak intention of agencies to impose 'corporate *mens rea*' in WRD cases (Tombs and Whyte, 2007). Taking this study as a starting point, a more comprehensive analysis of updated data and new developments in the criminal justice system (such as the CMCH Act) may contribute to the criminology literature.

Tombs and Whyte's study (2007) provides insights that explain several issues that I used in this thesis, such as conceptualising corporate and safety crimes, agencies and the governments' role and effect in treating safety crime, the policing of safety crime etc.

Tombs and Whyte (2007) consider workplace deaths as potential safety crimes as a type of corporate crime. The researchers (2007, p.1) conceptualise safety crimes as:

> violations of law by employers that either do, or have the potential to, cause sudden death or injury as a result of work-related activities. [They] are…ubiquitous, have devastating physical (and psychological) effects, and carry with them enormous financial and social consequences.

This theoretical and empirical study provides a theoretical basis for the analysis of WRDs as corporate crimes by introducing a criminological approach even though the researchers went beyond criminology in their study (Tombs and Whyte, 2007).

Tombs and Whyte (2007) argue that safety crimes as a type of corporate violence deserve criminological attention even though they have remained invisible in the criminology literature. Tombs and Whyte (2007, p.105) state, after evaluating some of the research, that 'all have taken some aspect of safety crime as one focus, and all attest to the fact that the actual level of corporate offending not only far outweighs that recognised by official data but is in some generalised sense comparable to conventional offending.' Police and non-police agencies – for example, the HSE – have responsibility for investigating corporate offences. This thesis is interested in the role of regulatory agencies, such as the police and CPS, in the investigation and punishment processes.

Tombs and Whyte (2007, p.93) highlight important differences between the policing of safety (corporate) crimes and street-level crimes:

- The investigation and prosecution of safety crimes is in the remit of the regulatory authorities rather than police forces.
- This process of administrative differentiation places responsibility for a huge number of offences in the hands of a relatively small agency.

Their study will be helpful in analysing my findings. For instance, Tombs and Whyte (2007) indicate a critical point of help to understand agencies' problematic policy that only specific types of wrongdoing are prosecuted by agencies due to established policy.

This explanation will be helpful in the analysis of the categories presented in Chapter 5, particularly for 'no information' and 'no further information on court processes' cases. Tombs and Whyte (2007, p.94) conclude that

> […] very often, the differential treatment of safety crimes – the informal way that safety crimes are often dealt with by regulatory agencies – produces a gap between the breaches of criminal law that are uncovered by the authorities on the one hand, and the breaches that are processed and recorded as such on the other.

This explanation will help to analyse the categorised prosecution and punishment types of WRDs (see Chapter 5).

Aligned with this, Tombs and Whyte (2007, p.91) argue:

> One obvious category for including records of safety crimes is that covering homicide, manslaughter and violent crime. However, the crime of manslaughter in England and Wales has been legally and socially constructed in a way that renders it inapplicable to corporate offences/offenders, not least because of the centrality of *mens rea* ('knowing mind') to this offence.

The analysis of the vignettes and cases provides insights to comprehensively evaluate this explanation.

Tombs and Whyte (2007) interrogated the HSE's role in the WRD prosecution process. The researchers analysed the statistics of WRDs published by the HSE by paying attention to HSE policy. The findings of Tombs and Whyte (2007) guided my research project in various ways, such as showing the importance of HSE statistics and the need for further research and for providing theoretical grounds to evaluate the results. This was another insight that guided the thesis and prompted me to include alternative sources (mass and local media outputs and other official documents) in the analysis.

## 3.2 Corporate (workplace) violence and harm.

### 3.2.1 Corporate violence

Corporate violence against workers has been determined in various official papers and criminology literature. Tombs (2007) demonstrates that criminological studies do not cover corporate violence that leads to workers' deaths by examining some relevant sources. These sources are the Oxford Handbook of Criminology, the Economic and Social Research Council (ESRC) Violence project and contemporary academic work on workplace violence within the UK (Tombs, 2007). My argument against this is that criminology must pay attention to deaths and fatal injuries in the workplace as an essential research topic where the definition of violence should include various forms of workplace harm.

***Causes and boundaries of corporate violence***

The reasons for fatal injuries are behaviour and activities of violence (World Health Organisation, 2014). Though different studies explain the causes and boundaries of corporate violence, many (Forti and Visconti, 2020; Bowie 2002; Punch, 2000; Hills, 1987) claim that the decision of a controlling mind, organisational structure and the inefficiency of the criminal justice system contribute to the occurrence of corporate violence. However, not all injuries and deaths occur due to crimes (Croall, 2001). Even though it may lead to dangerous consequences, corporate violence is not accepted as violence because violence is mostly conceived within the context of street-level offences rather than corporate ones (Forti and Visconti, 2020). Similarly, Punch (2000)

states that managers' behaviours, the working environment, and lack of a deterrent regulatory approach are fundamental conditions behind corporate violation. The author determined four particular reasons for escaping from punishment: (i) difficulties in detecting a relationship between behaviour or a decision and the accident; (ii) regulations pay attention to individuals rather than organisations; (iii) company owners and managers are differently represented in court thanks to their professional barristers, physical appearances and economic background compared to street-level offenders; and (iv) the power of economic world (Punch, 2000). The author addresses some possible consequences from this last reason that

> Business may have an excellent relationship with the regulators and may even "capture" them; can mobilize teams of top corporate lawyers against less experienced public prosecutors; can produce overwhelming amounts of evidence to swamp proceedings with data that delay proceedings and confuse juries; and is frequently successful in plea-bargaining its way out of the criminal courts and into the civil or administrative ones. Regulators and government-prosecutors may simply baulk at the thought of taking on corporate giants in long, expensive and uncertain trials (Punch, 2000, p.273).

These characteristics of offenders provide advantages in the investigation and punishment processes (Punch, 2000). Punch's analysis presents features of 'the crimes of the powerful', which as a concept within critical criminology are broadly explained later in this chapter. The author (1996) preferred to use 'law violation' and/or ''organisational deviance' instead of 'crime' to cover an extended area of law such as private law, and wrongful behaviour and activities. These explanations help this research to shed light on findings regarding the prosecution and punishment processes of WRDs.

Determining the context of violence is challenging for several reasons (Waddington, Badger and Bull, 2005). Violence occurs in a broad range of areas such as daily life, workplace and at home. Violence may not be considered harmful by the victims. Victims may not be aware of the violence. The reason is that there are indirect indicators to show the connection between consequences and harmful action (Waddington, Badger and Bull, 2005).

### 3.2.2 Corporate harm

The activities of corporations produce various types of harm: economic, environmental, psychological, physical and social. The activities, inaction and irresponsibility of a corporation and the state can lead to serious harm to people's lives (Criger, 2011). Corporate harm leads to multiple victims rather than being a 'victimless crimes' (Punch, 1996, p.84). This harm imperils the environment, employees, citizens and customers (Croall, 2001). Hillyard and Tombs, (2007, p.17) list physical harms that some of them: 'premature death or serious injury, violence such as car 'accidents, some activities at work (whether paid or unpaid) and exposure to various environmental pollutants'. Safety crimes can be distinguished from other corporate crimes by the

harm companies cause, which is physical harm (Croall, 2001). Some researchers pay attention to this type of crime, such as Tombs and Whyte (2007), Pearce and Tombs (1998) and Braithwaite (1984). This thesis focuses on fundamental corporate physical harm – deaths – and reifies obscured corporate harm (see Chapter 5).

## 3.3 Conceptualising safety crime as corporate crime

The conceptual framework of white-collar and corporate crime is covered in this section because it is a controversial and complex issue, according to the literature (Galvin, 2020; Simpson, 2013). It would be helpful to clarify the concepts for the reader. I have reviewed recent and prominent attempts to conceptualise corporate crime under this title. Some other relevant definitions and approaches such as Sutherland (1949), and Quinney (1964) have not been placed under this title because these definitions and approaches were discussed in Chapter 1.

Punch's wide-ranging description (1996) provides a reasonable basis for defining corporate crime and its categories.The writer states that severe physical and other harms, and victims of such harms, may arise from a lack of a set standard and clarity when applying rules and regulations (Punch, 1966). The importance of the clear and concise application of the law and regulations is evident in the UK criminal justice system, the approach of which to the criminal activities of corporations has been varied (Braithwaite, 1984). The criminal justice system investigates some workplace deaths and punishes those responsible under the Health and Safety Act 1974, while others are evaluated under corporate criminal law or common law (see further detail in Chapter 5). The lack of precise and determined agencies, along with various pieces of legislation and regulations present a complicated picture (see IntroductionChapter 1). The intricate workings of the criminal justice system can be observed from the punishments handed down (Arewa et al, 2018). These authors conducted a study similar to this thesis research, in which they sought to analyse the HSE's conviction data by applying mixed research methodologies. Their article provides insights that guided the present research project by helping to determine the boundaries and deficiencies of the thesis. While they researched only safety crimes and related general trends in penalties over 10 years to the size of the companies involved, my research examines not only safety crimes and their statistics but also corporate manslaughter cases; and it includes an analysis of non-punished case types. Apart from the methodological and theoretical differences, I have used a more extensive selection of databases, such as mass-local media output, LexisNexis and Courts and Judiciary.

One more relevant notion here: the 'crimes of the powerful' is worth a mention because this term is discussed broadly in the literature (see, Hébert, Bittle and Tombs, 2019; Bittle et al., 2018;

Frauley, 2018; Ruggiero, 2015; Matthews and Kauzlarich, 2000; Punch, 1996; Pearce and Tombs, 1998) and provides essential insight into the police and non-police agencies' roles in corporate offending.

### 3.3.1 The crimes of the powerful within critical criminology

The crimes of the powerful (CotP) has been incorporated into various theoretical perspectives (Bittle et al., 2018); thus, evaluating this concept within critical criminology is necessary. It is necessary to explain what this term refers to in the literature initially. It has been produced and reproduced by critical criminologists, some of them are Anne Alvesalo, David Whyte, Frank Pearce, R. J. Michalowski, Steve Tombs, and Steve Box.

Critical criminology provides fundamental insights into examination of corporate crime. This insight derived from (is) critics of criminal justice system and mainstream criminology regarding prioritised crimes and its definition. This criticism is that mainstream criminology (also called conventional or positivist criminology) accepts a narrow and problematic legal definition of crimes and criminals; and criminology mostly pays attention to these crimes (see, Box, 1983; Alvesalo and Tombs, 2002). Accordingly, the criminal justice system perceives specific wrongdoing as a serious crime, such as robbery, theft and assault, which pass through the prosecution and punishment process (Box, 1983). These criticisms allowed us to establish the research questions of this thesis and examine this criticised view of the criminal justice system in the context of safety and corporate crime.

The critical criminologists (such as Tombs and Whyte) explain the significant conditions and problems related to the CMCH Act and corporate manslaughter, including the reasons behind the delay in enacting the Act (see Chapter 2). Fundamentally, this notion has been utilised to indicate the characteristics of corporate crimes and understand agencies' roles in their inquest and punishment processes of corporate crimes. White-collar crime and corporate offences are crimes of the powerful (CotP) defined by potential perpetrators' economic and political characteristics. Here, 'the powerful' are defined as large companies, institutions, states, elites, and influential groups (see Pearce, 1976). However, criminal activities of low-level employees cannot be included within the bounds of perpetrators of corporate offences (Ugwudike, 2015; Ruggiero, 2015). Senior executives, owners of companies and politicians can be seen as potential perpetrators within the concept of CotP (Weisburd and Waring, 2001).

The critical criminologists indicate critical discourses help to conceptualise concept of the CotP as follows:

- the complicated web between political power and companies (Box, 1983; Bittle et al., 2018);
- the relationship between limited corporate liability and reproduction of capital (Bittle et al., 2018);
- the state or its reflection in practice support powerful groups regarding their wrongful actions in the criminal justice system (Pearce, 1976; Box, 1983; Frauley, 2018);
- highlighting 'the internal (i.e., necessary) relations that bind the capitalist state, ruling class and organised crime (Frauley, 2018, p. 3)'.

Critical criminologists provide a framework to understand corporate crime's perception within the criminal justice system by questioning why some harmful actions are not seen as a crime by governmental agencies. The answer may be hidden in the connection policy and the economic system (Frauley, 2018; Box, 1983). Bittle et al. (2018) argue that the difficulties of obstructing potential corporate violations can be seen in every country. They claim that CotP are ignored deliberately by governments and these crimes happen as an outcome of the exercise of corporate power in economic and social life rather than as a basic result of the violation of state-regulated laws and acts. One of the key claims commonly shared by critical criminologists is that large organisations and/or powerful actors rarely in court and face punishment considering workplace corporate offending even though the legal liability allows it (Hébert, Bittle and Tombs, 2019; Glasbeek, 2018; Tombs, 2018).

Punch (1996) identifies legislation policy that governments restrict economic activities by preserving companies' interests, therefore legislation structure is complicated.

The power of business and the importance of companies' financial profit to the state lead not only to the condoning of criminal activities but also to effectively rendering them invisible (Barak, 2017). Punch (2000) identifies some of the ways this occurs in practice: using expensive lawyers, and having a clear record, and a ‘respectful’ image. All are ways of avoiding sanctions in the court (see Section 3.2.1 Corporate violence).

Similarly, Croall (2003) argues that CotP explicates how governments regulate economic activities by paying attention in favour of the market. These arguments make it necessary to analyse cases that might demonstrate how the criminal justice system and the investigative processes operate in terms of addressing corporate wrongdoing. It should be noted that governments and other stakeholders of political power (local governments, institutions and politicians) have a crucial role in addressing this inequality and the invisibility of corporate crime. One of the important roles is

that the government shapes the descriptions of the crime and the offender (Dodge, Bossick and Antwerp, 2013; Slapper and Tombs, 1999; Pontell, Calavita and Tillman, 1984).

One of the main contributions of critical criminology to this topic is that it establishes the nexus between political circumstances and the committing of corporate wrongdoing and harm, and sets assumptions necessary for the analysis of this nexus (Pemberton, 2007). In this regard, Criger (2011) states that critical criminologists have changed the fundamental theme of criminology regarding individual definitions of crime and individual punishment aspects by suggesting a broad and fair approach. It is, therefore, a reasonable assumption that the notion of CotP and the view of critical criminology form a notable theoretical camp within criminology in terms of understanding corporate and state offences (see Barak, 2017; Rothe and Kauzlarich, 2016; Ruggiero, 2015).

Notwithstanding this, Hill and Robertson (2003) state that critical criminology has not made a revolutionary contribution even though its valuable attempts include putting problems on the criminology agenda, such as the wide variety of corporate harms ignored by the criminal justice system. In doing so, Hill and Robertson (2003) criticise critical criminology because the fundamental issues of society cannot be examined within the criminal justice system. Additionally, this notion and critical criminology might lead to the idea being ignored that individuals (with no power or less powerful) commit crimes and go unnoticed and unpunished (Hall and Winlow, 2018).

CotP has two theoretical limitations in terms of my research: it mostly covers the actions of large organisations (Bittle et al., 2018) and it generally encapsulates the grand narrative of states and capitalist economic production regarding crime and the criminalisation process. The first shortcoming falls outside the scope of this thesis since the actions of small- and medium-size companies are also covered here.

The connection between theoretical comprehension of corporate crime and their treatment in the criminal justice system helps create a critical discussion regarding the perception, punishment and prosecution processes.

## 3.4 Characteristics of the treatment and punishment of corporate crime

Criminology is broadly interested in the activities and functions of governmental agencies such as the police, courts and prisons, regarding street-level crimes rather than corporate crimes (Braithwaite, 2000). The examination of corporate offending in terms of punishments and the criminal justice agencies' role will contribute to existing criminology literature. This section

reviews the studies by focusing on problems related to punishment and corporate crime regulatory strategies.

### 3.4.1 Punishment of corporate offending

The consideration of corporate offences brings the problem of whether to punish individuals and /or organisations (Levi and Lord, 2017; Gray, 2006). There is the further question of whether an action is a crime or not for crime-related agencies and this uncertainty may constitute an impediment for the inquest (Levi and Lord (2017).

#### 3.4.1.1 Central problems concerning the punishment of corporate offending

The debate around the punishment of corporate crime indicates central problems such as the system's limited ability to punish companies' actions, a lenient punishment approach, and insufficient regulatory effort to secure justice.

The problem deemed by criminologists is that white-collar criminals have not encountered prison sentences as often as conventional criminals, which leads to injustice (Galvin, 2020; Campbell, 2019; Reiman, 2007; Slapper and Tombs, 1999; Box, 1983). Governments generally send corporations and powerful actors to courts under civil law and regulations instead of under the criminal law (Galvin, 2020).

Braithwaite (1984) considers that sending high-status people to prison may not necessarily provide justice; it only increases the number and types of people in prisons. He also claimed that the enforcement of regulation and deterrence could prevent corporate crimes before crimes occur.

The CMCH Act introduced significant fines for corporations; this is where the legislation was a critical attempt to secure justice by punishing larger corporate bodies with complex structures which make it nearly impossible to pinpoint responsible actors. However, this has been deemed inefficient for several reasons (Tombs, 2018). For example, fines do not help promote healthy and safe working conditions because the penalties are not given for this reason: the aim is to warn the offending companies about their criminal activities. These fines should be given to improve health and safety conditions. Thus, high penalties create problems, such as increased costs and decreased salaries (Tombs, 2018; Slapper, 2010). Slapper (2010) explains the punishment strategies applied in the criminal justice system: no massive fine can bring justice for a lost life. Even though it is written in the law, the penalty should meet 'the seriousness of the offence' and the legal agent should pay attention to the criminal's economic condition in handing out a penalty (Slapper, 2010). The findings in the light of this theoretical knowledge allow this thesis to include a

comprehensive discussion of punishments of corporate manslaughter, and to make a wide-ranging analysis of sanctions such as community orders and the various levels of fines imposed (See Chapter 5).

In the criminology literature, it is often stated that corporate crimes are different from street-level crime regarding punishment, investigation, controlling and the level of seriousness (Punch, 1996; Croall, 2001). I argue that differences between corporate and street-level crimes are questionable in various ways, even though the differences may be apparent in practice.

Croall (2001) takes a different approach to these dissimilarities, stating that street-level crimes such as robbery and burglary may be like corporate crimes in terms of invisibility, complexity and the arduous identification process of crime. For instance, experienced offenders share duties and power to reduce the possibility of investigation and getting punished. This explanation suggests that some characteristics of corporate crime are invisible and difficult to prove but is not an acceptable excuse for the low number of prosecutions.

### 3.4.2 The policing of safety crime

A comprehensive investigation of workplace corporate offending needs to include policing/regulatory strategies. Even though 'policing' refers to deployment for conventional crimes, the investigation of corporate offences has various components related to policing (Levi and Lord, 2017). The main strategies of policing safety crime, such as compliance, deterrence, and punishment, provide insights to identify the weaknesses and strengths of policing strategies. Policing of safety crimes refers to the relationship between governmental and non-governmental agencies and public and private actors that control regulation (Levi and Lord, 2017).

#### 3.4.2.1 Punitive and compliance policing strategies

Pearce and Tombs (1998) argued that a punitive policing strategy and law should be applied to safety crimes as corporate crimes, contrary to the compliance school. The compliance camp does not see prosecution and severe punishment as a sufficient solution while the punishment camp advocates punitive action and regulation (Gray, 2006). The advocates of compliance argue that corporate and conventional criminals are not similar rational actors (Gray, 2006). Corporate criminals contribute to the economy and society; thus, they 'are capable of being socially responsible' while street-level criminals are more dangerous; more severe policing should be applied to conventional offenders (Gray, 2006, p. 877).

Pearce and Tombs point out that corporations are rarely accepted as 'amoral calculators' by compliance school scholars (1998). They also argued that corporations generally violate

regulations because they are 'amoral calculators' and tend to break the law. Punch (1996) argues that corporate criminals aware that they are *committing crime*. The compliance regulation strategy accepts companies' self-regulation in obeying safety rules as their own responsibility, and proposes that prosecution and punishment for breaking laws should be a last resort (Gray, 2006).

#### 3.4.2.2 Reintegrative approach to safety crime

Braithwaite (1984) states that corporate offences have been mostly evaluated through a legal approach, and the connection between regulators and corporations is ignored. Several criminological studies on corporate crime have been conducted since 1984, and some emphasises the importance of an internal regulatory policy rather than a strict and punitive approach (Gray, 2006; Croall, 2001; Hawkins, 1990). Braithwaite (1984) infers that the agencies could be successful by using the legal power of communication with a corporation, in this way, more accidents could be prevented rather than applying corporate criminal law and severe punishment. Braithwaite (1984) advocates punishment in some conditions but he perceives a more lenient strategy for corporate crimes compared to the punishment (punitive) model and calls attention to agencies' role in this process regarding the efficiency of a strategy. The authors point out that some negligence derives from workers' behaviour (such as ignoring safety rules to save time) (Braithwaite, 1984).

Braithwaite (1984) evaluates the advantages of the reintegrative approach in terms of certainty and punitive punishment. The expectation is that justice can be provided by applying severe punishment to corporate crimes compared to conventional crimes. Although sending white-collar criminals to prison seems like one method of punishment, it should be evaluated as a final option when it becomes the only option to save people frgrom harm (Braithwaite, 1984). Braithwaite (1984, p. 290-293) offers several regulatory strategies to prevent corporate crime. For instance, the regulations and Acts can be applied more efficiently and quickly, 'rehabilitation' and making 'restitution' to victims of crimes.

#### 3.4.2.3 Situational crime prevention approach

Huisman and Erp (2013) create a preventative policing strategy called the Situational Crime Prevention Theory (SCPT) that shows a link between determining the policing-prevention approach and the concept of corporate crime depending on findings. There is a strong connection between corporate crime and controlling economic activities (Punch, 1996). The controlling of economic activities such as capitalist production prioritises different actors' interests, for instance, corporations, society and governments (Punch, 1996). Companies' illicit activities are restricted, and governmental institutions decide to label an activity as 'a crime'. The in-depth examination of

workplace deaths regarding prosecution and punishment process provides insights to evaluate which kinds of activities have been considered as a crime.

Huisman and Erp (2013) claim that routine activity is a proper perspective for corporate crime because it occurs in the working area and as a part of daily life. The researchers claim that a prevention strategy should be based on the opportunity structure of white-collar crime. For instance, as a first step, corporate crime can be treated like street-level crimes and then the strategies can be improved based on the uniqueness of corporate crime (Huisman and Erp, 2013). This approach may allow the prosecution processes of safety crimes and their relationship with regulatory strategy to be evaluated. At first glance, the implementation of legislation against workplace corporate offending is similar to street-level crime; however, in-depth analysis of the prosecution process may indicate the differences.

Gobert and Punch (2007) address three central points to investigate white-collar crimes: first, criminals intend to do what they commit. The second point is that a criminal's act should be evaluated as a rational choice even though they do not expect to encounter a severe result, which somehow leads to the lines between criminal and wrongful action being masked (Gobert and Punch, 2007). The third point is that 'the contextual ambiguities in the law encourage would-be offenders to believe (or be able to rationalise to themselves) that they are not engaged in unlawful behaviour (Gobert and Punch, 2007, p. 101).

#### 3.4.2.4 Internal regulation approach

Gray (2006) calls attention to violated workplace regulations regarding workers as important actors rather than governmental and non-governmental institutions. He claims that workers may become responsible for safety violations. Workers may sometimes ignore rules, and they may not resist working in places where some safety measures are not taken. However, the thesis argues that corporate crime in the workplace cannot be prevented by focusing on workers' responsibilities or accepting workers as important actors in committing safety crime. The reason is that it is the company that controls the workplace and the working conditions and (as the most powerful actor holding administrative power) determines workplace rules.

#### 3.4.2.5 The latest regulatory strategy: CMCH Act 2007

The Health and Safety Executive (HSE) defines work-related violence as 'any incident in which a person is abused, threatened or assaulted in circumstances relating to their work' (Health and Safety Executive, 1996). The HSE cites relevant laws and regulations: the Health and Safety at Work Act 1974 (HSW Act), the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), the Safety Representatives and Safety Committees Regulations 1977

(a) and the Health and Safety (Consultation with Employees) Regulations 1996 (b). Exclusively, the Corporate Manslaughter and Corporate Homicide Act (the CMCH Act) covers only deaths caused by corporate violence as part of corporations' economic (production) activities (Forti and Visconti, 2020).

The knowledge derived from the policing of corporate crime allows the applied current policing strategy and its efficiency to be discussed. I evaluated the case studies and the relevant findings of this thesis in the light of these policing (regulatory) strategies.

## 3.5 The seriousness of corporate offending

The issue of whether a corporate offence is a severe offence is one of the central debates within corporate crime on methodological and political grounds, the language used in documents and the perception of crime-related institutions.

*The methodological and political importance of seriousness*

Benson, Kennedy and Logan (2016) propose that the seriousness of corporate offending should be considered as a critical methodological issue in research (see Chapter 1). This discussion is important because it affects how corporate offending is evaluated in the criminal justice system. Kramer, Michalowski and Kauzlarich (2002) elaborate on this by pointing out that the interests of government and giant corporations can be observed through the features of crime definition, though we may not find the notion related to the damage of economic and political activities to society.

Punch (1996) discusses the seriousness of corporate crime on a political ground that governments do not perceive corporate offending as a fundamental and severe problem. However, this perception makes the issue political, and this situation damages the formation of a fair evaluation basis in the criminal justice system which creates a trustful environment for business activity (Punch (1996). Governmental institutions' responses to corporate crime indicate the seriousness level of corporate crime.

### 3.5.1 Agencies' perceptions of corporate offending

In the criminology literature, the seriousness of corporate offending has been investigated through the document and discourse analysis of judicial decisions based on the language used in the media and courts. Recent research on corporate manslaughter by Hébert, Bittle and Tombs (2019) scrutinises inquests involving the CMCH Act considering the seriousness of corporate offending and the performance of this act in practice in the UK. The theoretical grounds of this

research are based on the crimes of the powerful. The researchers aimed to understand the relationship between the capitalist system and legislation on corporate violence by analysing the perception of corporate offending in the criminal justice system and establishing whether it is considered a serious crime. Specifically, this research focused on the language used in the reports of verdicts, media and other agencies. The analysis of the data obtained from participants and internet research shows that corporate violence was not seen as 'true' crime. This perception was reflected in the relatively low number of cases prosecuted under the CMCH Act. Additionally, the authors claim that this perception plays a pivotal role in the final court verdicts, as evidenced by the language used in conviction cases.

This thesis has identified the characteristics of various court cases investigated under the CMCH Act and made a statistical and documentary analysis of workplace deaths to understand criminal justice agencies' perception in terms of seriousness. The delineation of successful, unsuccessful and non-prosecuted cases can explain why some work-related deaths can be evaluated as corporate manslaughter while others are not (see Chapter 1).

*The reasons behind the problematic perception of safety crimes*

Safety crimes are generally perceived as wrongdoing as a result of technical failure. In contrast, conventional crimes are perceived as an unethical and unlawful act that causes severe damage to society (Levi and Lord, 2017; Friedrichs, 2015). Almond and Colover (2012) similarly describe the problem that workplace crimes had been evaluated out of criminal acts for a long time, and these crimes are not perceived as instances of 'mens' rea'. Workplace safety crimes are seen as a natural result of economic activities instead of unlawful action (Almond and Colover, 2012).

The seriousness of work-related corporate offending shows the importance of agencies' approach to WRDs in defining incidents as crimes or accidents. This discussion helped me to analyse WRDs through the case studies and crime vignettes by showing the effect of seriousness in the investigation and punishment processes.

## 3.6. Importance of agencies in the punishment and prosecution processes

Police agencies can identify a workplace death and punish the incident as a corporate manslaughter once they evaluate it as an action that resulted from breaking the law. The investigation and punishment processes provide various insights to evaluating corporate offending. Therefore, the agencies become important actors in their approach to cases and their role in implementing acts and laws. Many researchers emphasise the police and non-police agencies' role in the prosecution process and in punishment (Gottschalk and Benson, 2020; Hébert, Bittle and Tombs, 2019; Simpson, 2019; Tombs and Whyte, 2007; Gray, 2006; Pearce and

Tombs, 1998; Braithwaite, 1984). Otherwise, these studies do not analyse in depth the role of agencies and factors that affected the prosecution and punishment process of WRDs cases that happened in the eight-year period 2008-2016 by applying a particular research design (see Chapter 4 for further information), apart from Tombs and Whyte's (2007) empirical and theoretical study published 15 years ago.

The debate on policing strategies also indicates that even non-governmental agencies treat and punish safety crimes showing the critical roles of agencies. Simpson (2019) states that crime agencies that play a role in the prosecution and punishment process have not paid great attention to corporate violations in the criminal justice system due to one empirical study (see this empirical stud; Baer, 2019). Simpson's (2019) critical approach to this assumption is that the examined cases may consist of small- or medium-sized companies.

Roper (2018) underlines the importance of prosecutors' skills and attention, both of which are essential to the successful conclusion in complex cases. Here, Roper refers to the lack of qualified members of institutions and the inexperience of these kinds of cases. She also points out that untrained agency staff may not solve complicated cases. Her study is significant in highlighting the importance of agencies in the prosecution process. She stresses that members of governmental agencies should be qualified for pre- and post-inquest processes, such as preparing reports and paying attention to cases. Roper points to the relatively high number of work-related deaths despite the low number of prosecuted cases and poses the critical question, 'why there have not been more prosecutions, as predicted at the Act's implementation' (2018, p. 65).

In parallel, Tombs (2018) addresses the HSE's and CPS's role in the prosecution process; the diligence of inspectors also plays a critical role in the number of cases that courts have not charged. Hébert, Bittle and Tombs (2019) identify features of cases involving criminal agencies that courts have not evaluated under corporate manslaughter. One of these features is that these companies tend to ignore the HSE's cautions, mostly due to the cost of training and putting health and safety measures in place, especially if the company's economic position is in danger (Pearce and Tombs, 1998). Companies and agencies need to train workers and educate them to prevent harm, but promoting this training is not an efficient solution (Pearce and Tombs, 1998).

Additionally, Hébert, Bittle and Tombs (2019) acknowledge that reports and publications from both the CPS and the police are important resources for analysing cases. Punch (1996) draws a picture of the unequal relationship between companies and agencies showing that, even though corporations have power in socio-economic and political areas, agencies have limited control over corporations due to the lack of trained staff and a restricted budget. These relationships may lead to a low number of prosecutions and to a low fines (Punch, 1996). Likewise, Croall (2001)

associates the few investigations with a restricted number of health and safety staff and limited resources. The writer supports this argument by quoting a discussion in the House of Commons, which revealed that only one case was investigated out of ten reported cases (Croall, 2001).

This discussion highlights the importance of staff knowledge in the prosecution process. Examining the role of staff may provide valuable insights in determining the factors and roles in successful and unsuccessful work-related corporate offending. Indeed, these studies encourage the researcher to focus on agencies' roles. Additionally, it helped to generate interview questions for agencies to help understand their role; for example, whether they need specific training, and the challenges they face within the prosecution process.

## 3.7. Summary

The criminology literature on corporate crime indicates a central problem related to the punishment and treatment of corporate offending in that some corporations are less likely to be prosecuted and punished (Galvin, 2020; Hébert, Bittle and Tombs, 2019; Tombs, 2018); the low number of convicted cases is proof of this reality. Possible reasons for this problem have been put forward by scholars and include the insufficient structure of law (Whyte, 2018; Tombs, 2018), the unwillingness of crime-related agencies and the agencies' role (Tombs, 2018; Tombs and Whyte, 2007), corporate and safety crimes not being perceived as serious crimes (Hébert, Bittle and Tombs, 2019), agency staff being insufficiently trained (Roper, 2018) and workers' responsibility in the cases (Gray, 2006). Another important criticism is that the causes of WRDs have overwhelmingly been seen as technical failures or natural events rather than the illegal acitivities of companies (Almond and Colover, 2010; Tombs and Whyte, 2007).

The most common findings of relevant studies that address the performance of corporate liability can be summarised as follows:

- There have been a low number of convictions (Galvin, 2020; Hébert, Bittle and Tombs, 2019; Tombs, 2018; Benson Kennedy and Logan, 2016).
- Senior management test in company structures during the prosecution process has not been thoroughly tested due to an inadequate number of instances (Tombs, 2018).
- Corporate offending related to work-related deaths has not been seen as a serious crime (Hébert, Bittle and Tombs, 2019; Tombs, 2018; Almond and Colover, 2010; Tombs and Whyte, 2007).
- The legislation process on corporate manslaughter remains inoperable (Hébert Bittle and Tombs, 2019; Tombs, 2018; Whyte, 2018).

- The seriousness of the corporate violence is problematic compared to that of street crimes (Hébert, Bittle and Tombs, 2019; Benson Kennedy and Logan, 2016; Almond and Colover, 2010; Tombs and Whyte, 2007; Tombs, 2007).
- Safety and corporate crimes have been invisible in the criminal justice systems (as can be observed through a lack of official data and lenient perception) and the criminology literature (Hébert, Bittle and Tombs, 2019; Benson Kennedy and Logan, 2016; Tombs and Whyte, 2007; Tombs, 2007).

The literature on the CMCH Act has assessed the legislation's efficiency by investigating cases occurring before and after its introduction. This methodological approach reinforced the rationale for selecting appropriate case studies and vignettes for this thesis.

The limitations of the existing literature can be listed as follows:

- Most studies have focused only on convictions and non-convicted cases under the CMCH Act. There have been two exceptional studies: Tombs and Whyte (2007), which was published 15 years ago, and Arewa et al., (2018), which is out of scope of criminology and limited compared to this study.
- Although almost all existing studies have used HSE records (Hébert, Bittle and Tombs, 2019; Roper, 2018; Tombs, 2018; Almond and Colover, 2010; Tombs and Whyte, 2007), many lack sufficient detail or have not used the most recent databases.
- To the best of my knowledge, studies that use empirical data to focus on the role of agencies and factors within the prosecution and punishment process of safety crimes have not been recently exist.

Comprehensive research on corporate offending regarding the prosecution process can contribute to the safety crime literature. Indeed, a comprehensive analysis of these data does not exist. Additionally, other work-related cases prosecuted under health and safety law and common law have been understudied; most existing studies focus only on companies convicted or acquitted of gross manslaughter. These studies have not focused on the role of the actors and conditions. Few studies borrow theoretical and methodological foundations from academic disciplines outside criminology (Parsons, 2018; Roper, 2018). A few studies have conducted interviews with key actors, such as lawyers, managers and members of agencies that investigate corporate crimes (Huisman and Erp, 2013; Pearce and Tombs, 1998; Braithwaite, 1984).

Thus, there is a need for an in-depth examination of the factors influencing successful and unsuccessful prosecutions. Such an investigation would be useful to clarify the efficiency and role of different components, such as the act itself, as well as actors, such as the police and courts.

# Chapter 4 Methodology

## 4.1 Introduction

In this research I used mixed methods, comprising, documentary analysis, statistical analysis, case studies and vignettes to understand corporate offending in the workplace. Having set this general methodology, in this chapter I focus on four main areas: *data collection, data analysis, ethical considerations, and limitations and challenges*.

Data collection consisted of two main parts: 1) *Types of data: records and documents;* and 2) *Semi-structured interviews*. I identified document sources such as mass media (national newspapers, broadcast media and websites such as, Guardian and BBC) and local media outputs (newspapers, websites and radios distribute within service area such as, cities and counties), Health and Safety Executive (HSE) records and various types of interviews: online, telephone and email.

Under the heading of data analysis, case study approach, vignettes, documentary analysis and statistical analysis are comprehensively explained. I identified two cases of workplace death and multiple vignettes that reflect different instances of the processes of prosecution and punishment: : 1) Cases prosecuted under corporate manslaughter law; 2) 'No information' and 'no further information on court processes' cases; 3) Cases investigated under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (inquest process and verdicts) regarding the result of the investigation and punishment process.

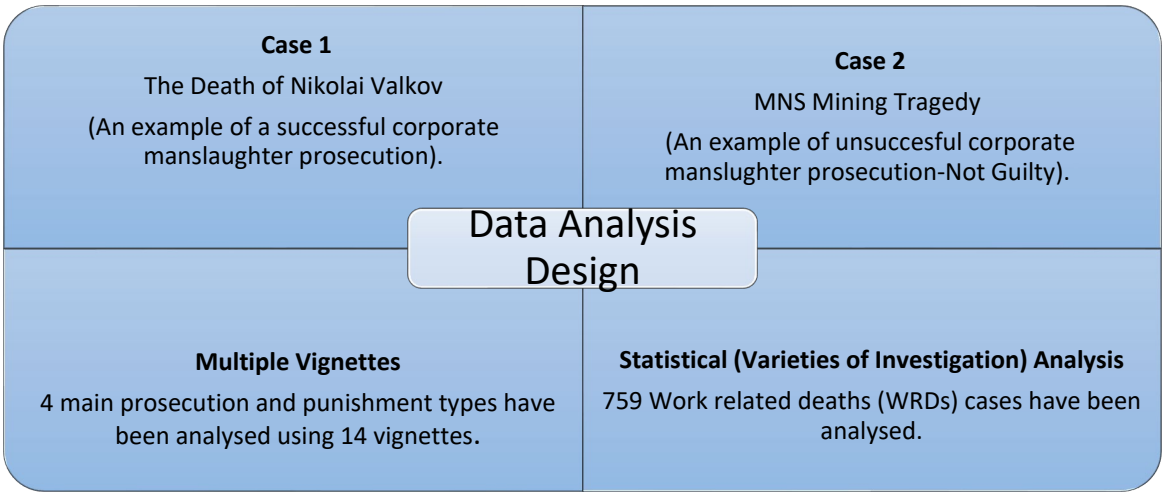



*Figure 4-1 Data analysis design*

## 4.2 Research methodology and methods

Mixed methodology can be applied in criminology and recently has been gaining in importance (Heap and Waters, 2019), even though researchers in criminology and other social sciences often applied qualitative or quantitative approaches decades ago (Trahan and Stewart, 2013). This research employs a qualitative methodology through case studies and vignettes while a quantitative method through statistical analysis (see Chapter 5) is used to address the research aims and answer the research questions. Mixed methods enable researchers to use different methods and effectively indicate the problems and analyse the findings in research (Heap and Waters, 2019). This is the main rationale for choosing a mixed methodology in this thesis. One of research question is How have UK government policy and legislation dealing with corporate crime been implemented in practice since 2008? Chapter 5 sets out to answer this question (and partially the third question) through statistical analysis (as a quantitative data analysis method) of the investigation and punishment process of WRDs. The other two research questions are:

2) Why can some corporate violence that resulted in deaths be seen as safety crime while others cannot?

3) What are the factors and roles of institutions that influence the prosecution process and the final decision?

In a qualitative investigation, researchers examine participants' experiences and approaches using document analysis and in-depth interviews (Denzin and Lincoln, 2003). Such a qualitative approach was chosen for this study to record and analyse the thoughts, behaviour and experience of the informants. Bryman (2012) stated that a researcher should analyse societal issues in the light of informants' views as they confer importance on people's knowledge. These characteristics of qualitative research methods have enabled me to (i) determine the role of agencies in prosecution and court processes and (ii) explore the factors in the final decisions taken by crime-related agencies. The quantitative method has helped to (ii) form a comprehensive picture of justice as applied to fatal workplace injuries and the characteristics of different court decisions. Employing mixed methodology help researchers to solve the limitations of applying only one methodology (Hartley, 2010). This methodological ground allows me to apply a quantitative strategy by using and analysing numbers in Chapter 5, and to apply qualitative methods; case studies, vignettes and documentary analysis in the rest of the thesis.

## 4.3 Data collection

This research used various sources and techniques. Various data collection methods were applied: official documents and database, mass and local media output as a fundamental data collection method, and semi-structured in-depth interviews as a supportive data collection method.

### 4.3.1 Types of data: records and documents

I placed various actors' discourse to make a critical and rigorous analysis and avoid bias. It is a critical point I paid attention to was being critical and objective to overcome the limitation of documentary analysis.

In this study, the documentary and statistical analysis involved various documentary and numeric data and sources:

- Mass and local media output
- HSE records
- Agency reports and speeches (such as sheriff's reports)
- Court hearings
- Legislation
- Coroner's reports
- Freedom of Information (FoI) Request

The analysis of these documents provided the opportunity to interpret the investigation and punishment processes of each case from the perspectives of the various actors were involved in the cases.

There have been many papers published on workplace corporate offending. The data provide valuable findings for understanding agencies' approach to the investigation and punishment of safety crimes. Denzin and Lincoln (2003) argue that research based on the real experience and knowledge of people obtained by various means such as case studies, interviews and documents are appropriate components of qualitative methodology to produce a convincing explanation of the research subject and problems. This is a fundamental strength of applied mixed methodology regarding triangulation. These various sources enable us to answer the research questions by using collected knowledge for analysis. These sources help to overcome the disadvantages of qualitative methodology, in which the data reflect the biased approach of participants (Bryman: 2012: Creswell, 2014). Thus, I paid attention to comparative knowledge from different sources in the analysis and discussion process and employed a quantitative method. I examined the views of

key actors such as the jury and the Crown Prosecution Service (CPS), as factors when analysing cases and vignettes.

#### 4.3.1.1 Mass and local-media output

Mass-media output sources are widely used in both quantitative and qualitative research (Bryman, 2012). I used newspaper articles to access information related to cases of workplace death. I examined not only major newspapers and websites such as the BBC, *Guardian* and *Independent* but also local newspapers. Additionally, the websites of critical agencies were important sources. These included the CPS, HSE and Safety and Health Practitioners (SHP). I scanned almost 350 websites and newspaper articles for (only one year period) annual statistics on workplace deaths. I skimmed and scanned more than 2,800 web pages to reach data about the results of the prosecution and punishment processes presented and analysed in Chapter 5.

I collected data including the following:

- Statements by agency staff about cases in the media and official documents.
- The results of the cases.
- The laws and regulations under which each case was investigated.
- The court and institutions related to the case.
- Punishment.

#### 4.3.1.2 HSE records

The Health and Safety Executive is one of the critical agencies in prosecuting work-related corporate offending. The agency publishes records on workplace deaths every year. I used the limited information included in this source: name of deceased, age, location of incident and authority, business sector, status such as employee, employed by others, self-employed or member of the public. I also accessed more comprehensive information such as:

- Who investigated the case.
- The outcome of the case.
- Under which law or regulation, the case was examined.
- Which court gave the verdict.

I examined eight years of workplace deaths (2008-2016) in this study. I started with 2008 because the CHCM Act came into force after April 2008. The rationale for stopping with 2016 is given in Chapter 5.

#### 4.3.1.3 Agency reports and speeches

I used three central agency sources: HSE, CPS and the court (Courts and Tribunals Judiciary). I generally accessed documents from these agencies from their websites.

I researched CPS reports and examined corporate manslaughter cases separately from HSE records. I accessed knowledge about this institution via its websites. I also tried to gather unpublished information from the CPS via a freedom of information request, but citing their policy on internal investigation, the agency declined to provide it (1 November 2022). Another attempt to gain data was shared but was provided late (requested in January 2023, responded in March 2023). I requested information via FoI from HSE; I received a response (in August 2022). The data gained from agencies is analysed in Chapter 5.

The other important sources were police reports on workplace death cases. I accessed only cases that occurred in Scotland. The sheriff report considering each case includes how the case occurred, and the main failings that led to an accident. The sheriff reports yielded significant data for the analysis of vignettes. Additionally, agencies' statements about a case placed in the media were examined.

#### 4.3.1.4 Court hearings

Criminal courts are one of the richest document sources for criminological research (Baldwin, 2000). I used the court hearings in case analysis. The role of government institutions can be discerned in this way. I gained two court hearings through the official EX107 and EX105 (transcription of Court or Tribunal proceedings) request forms. These documents included important information about cases: circumstances of death, the final verdict, the coroner's concerns and requested information from companies, institutions and experts.

#### 4.3.1.5 Legislation

The relevant acts (the CHCM Act and Health and Safety Acts) were accessed online. The analysis of these acts was used mostly in Chapter 2, but also to a lesser extent in other chapters. Transcripts of legislation about corporate manslaughter can be accessed online. These debates provide important information to understand the government's perception of corporate manslaughter and the boundaries of the Act.

#### 4.3.1.6 Coroners' reports

Coroners' Prevention of Future Death (PFD) reports were analysed for this thesis. The coroner can decide to share his or her concerns with relevant organisations and individuals to take action

(Leary et al., 2021). Recipients should respond to such a report within 56 days. The reports and their responses can be found on the website www.judiciary.uk. Five of these reports were analysed in Chapter 8. I gained access to court reports on 54 cases through 'Courts and Tribunals Judiciary'. These sources are open to researchers and can be used after an inquest.

#### 4.3.1.7 Reliability of documents

The analysed documents are written by agencies or journalised and these documents may not be unbiased (Denscombe, 2017). Additionally, the credibility of documents taken from the Internet may be a critical issue as the study relies to a large extent on documentary analysis (Bryman, 2012). I used various approaches to increase the credibility of sources. Firstly, I gave more information about the sources and the analysis process. Second, I checked information about each case with more than three sources (mainly applied in the statistical analysis). I mostly used official documents and agencies' 'Internet sources'. Moreover, I cross-checked information obtained from documents with interviews and different documents as much as possible.

### 4.3.2 Semi-structured interviews

Unfortunately, I only conducted four interviews with two different participants. It was difficult to access participants and organisations due to Covid-19 and the nature of the topic. The circumstances, as well as my supervisory teams and examiners, guided me to change my original plan. This issue is discussed in the section 'Challenges and limitations'.

Bryman (2012, p. 472) argues that semi-structured interviews are suitable for a multiple case study as they allow for 'cross-case comparability'. In this way, I could compare the participants' answers to identify the similarities and dissimilarities in a case. I prepared a list of questions for different types of participants to learn of their experiences and thoughts about the case's prosecution and punishment process. Bryman (2012) infers that semi-structured interviews can be held to reify a particular matter in the light of the researcher's directions, even though participants can answer the questions freely. Nevertheless, I asked some questions that were not on the question list if this was necessitated by the nature of the interview. Generating questions during interviews is an advantage of a qualitative methodology over a quantitative methodology (Bryman, 2012).

I held two types of interviews:

- *Online interviews*

One of the interviews was conducted online rather than face to face due to the Covid-19 restrictions in the UK. Interviews were conducted either face to face (depending on Covid-19

restrictions) or online via VoIP (Voice over Internet Protocol) technologies such as Skype, FaceTime, Facebook, Teams and Zoom. The critical advantages of online interviews are time and cost savings. Additionally, it is a safe environment for the interviewee and researchers in a time of pandemic. I used Teams for one interview.

- *Email and phone interviews*

Email interviews were added as an option to allow participants sufficient flexibility during Covid-19 restrictions and when limited for time that could be committed to the study due to working at home. I found that people preferred to be interviewed via email or on the phone rather than face to face.

I audio-recorded the interviews to provide a more reliable record than written notes (Bloor and Wood, 2008) and to make it easier to code and analyse (Bloor and Wood, 2008) the material.

The telephone interviews were done with a person who was involved in the first case. The first took approximately 40 minutes while the second took almost 20 minutes. The conversations were audio-recorded.

I communicated with one interviewee twice by email. I liaised with one of the participants for one month. The questions were answered and checked by more than one person who had worked for the HSE. After the first email interview, I sent another set of questions to the interviewee, who had worked as an inspector at the HSE for 12 years. The online interview was conducted via the 'Teams' application and took almost an hour.

#### 4.3.2.1 Approaching participants

Access to participants such as police, inspectors and people involved in the case – as a PhD student in criminology – was challenging. I attempted to overcome the problem by applying various strategies. In the first case, the people involved were Turkish, and I found some information that allowed me to contact them. I have the same ethnic background as the first-case participants, and this proved advantageous in building trust between us. I got consent from the participant to join the research.

I communicated with some participants via social network platforms such as Facebook, Twitter and LinkedIn as appropriate. I was planning to gain the consent of research participants by email and send letters as well. I provided information to the participants about the project and the use of data. After the first communication, I also sent a consent form securing the participants' permission to join the research. I accessed the officers through formal channels by sending a letter or an email to get permission to interview them. After conducting an interview with one

agency member, I planned to obtain referrals and recommendations from the first participant for the following interviews. These strategies only helped me find one participant.

Another logical step was to ask professionals who worked at the University of Southampton to use their networks to access agencies. I also contacted relevant professionals such as academics and experts via social media for help to access research participants. One of my supervisors wrote personally to two high profile ex-police officers neither of whom responded.

I also tried other means:

- My research was written up on the Research Map on the College of Policing's website in order to reach police and non-police agency members.
- I sent a request to the CPS and Police via email and made several phone calls to them during the Covid-19 pandemic.
- I reached actors involved in the first and second cases via phone, email and LinkedIn; an experienced researcher in policing also tried to reach them.

#### 4.3.2.2 Coding and translation of interviewees

The coding and translation of interviews are challenging processes for qualitative researchers (Bryman, 2012). I did not face coding problems; on the other hand, translating the interviews took a long time. I tried to reflect the interviewees' natural connotations and expressions when translating their Turkish to English.

I used an online application, 'Otter', to transcribe the interviews, which helped me to use my time efficiently. However, I checked each sentence by listening to the recording.

On the one hand, email interviews had advantages in terms of coding and transcribing. I did not need to transcribe this interview. On the other hand, it was impossible to get interviewees' statements as in a natural conversation flow.

I codified participants' names and discussed the issue of confidentiality with some of the participants. I sent a copy of the translation of one interview to the participant. The participant replied with a note of clarification (he/she thought some points were not clearly expressed). The small number of participants helped me to ensure anonymity in the Nikolai Valkov case. If there had been more than one participant, I would have had to apply additional precautions and processes to provide anonymity in that case. I could not conduct any interviews for the MNS Mining case, which provided more flexibility as people's identities were available in public documents.

## 4.4 Data analysis

Mixed methodology allows researchers to combine quantitative and qualitative methods (Bryman, 2012). In this project, quantitative data analysis (statistical analysis) has guided qualitative data analysis methods (particularly case studies and vignettes). Determined five different investigation results have been analysed via case studies and vignettes. The four methods of data analysis applied in this study were: multiple case study analysis, vignettes, document analysis and statistical analysis.

### 4.4.1 Multiple case study

The case study as a methodological approach yields a practical framework for in-depth investigation of a phenomenon (Yin, 2014). Yin (2014) emphasises the importance of consistency between research questions and method – case study – and the date of cases which should be recent. This led me to choose the case study method. In doing so, the process of exploring case studies was crucial, and some essential points had to be considered. Yin (2014) proposes important criticisms of which criterion and particular attempts should be clarified for conducting an appropriate case study, and the reasons behind features of the cases should be considered.

Stake (2009) suggests that case studies are appropriate for examining social problems and phenomena related to people. The importance of case studies related to the prosecution process and court decisions to understand safety crime as a type of corporate crime phenomena in the UK are well documented in the literature (Hébert, Bittle and Tombs, 2019; King and Lord, 2018; Tombs, 2018). The following studies provide insights to understand widely used case study methods in criminology literature.

#### 4.4.1.1 Common methodologies used in the corporate crime literature

Hébert, Bittle and Tombs (2019) investigated successful and unsuccessful prosecutions under the CMCH Act to show the impact of the act on corporate offending. The researchers used three different data sources: (i) a brief on five verdicts obtained from the Courts and Tribunals Judiciary website and through LexisNexis Quicklaw; (ii) cases prosecuted under the CMCH Act from 2011 to 2018 accessed via electronic tools and Internet research of solicitors and private lawyer firms; and (iii) public domain searches to investigate work-related deaths.

Gottschalk and Benson (2020) relied on published documents, such as new media searches and investigation reports on corporate scandals and corporations' actions against scandals. The

authors conducted their research through case studies and content analysis, and scrutinised the prevalent limitations on corporate crime.

Methodologically, Tombs (2018) built on the analysis of work-related corporate offending using HSE and CPS records (unpublished data) accessed by special request. It appears likely that these records served as the central resource for investigating work-related corporate offending. Here, two critical methodological issues were raised in the study of corporate manslaughter. The first issue is the importance of workplace deaths as well as prosecuted and non-prosecuted corporate manslaughter cases; the second is the limitation of the published data.

Some researchers (Campbell, 2019; King and Lord, 2018) have preferred to use case studies by investigating court decisions related to deferred prosecution agreements (DPAs) to understand corporate offending in the criminal justice system.

These studies, therefore, indicated that a multiple case study approach is suitable for this thesis to understand the implementation of legislation for work-related corporate offending. Stake (2009) argues that the case study method is an appropriate and satisfactory way of increasing understanding. The critical rationale for carrying out a multiple case study is to address the phenomenon differently (Yin, 2014). This explanation shows the case study is an appropriate method to secure one of the aims, which is to improve existing knowledge related to corporate offending in the criminology literature.

#### 4.4.1.2 Case selection

I chose a multiple case-study approach for this study to gain insights from different perspectives. Exploring multiple cases is more effective than single case in terms of the variety of evidence and being critical and reliable (Yin, 2014). The MNS mining case, the death of Nikolai Valkov might provide some similar outcomes to other cases and some different consequences in their separate accounts.

I selected cases according to three main rationales:

- The first is that all the cases happened after April 2008. The reason for this is that the Corporate Manslaughter and Corporate Homicide Act (CMCH Act) 2007 came into force after this date. The literature review indicates that the CMCH Act is a crucial attempt to solve fundamental concerns regarding the punishment and prosecution of corporate offending. The investigative process of these two cases has been finished. Yin (2014) argues that the selected cases should provide up-to-date data or different information but understandable reasons.

- The second is that each case reflects the different result of the verdicts on the cases related to corporate manslaughter. Each case has different characteristics that will provide valuable and comprehensive knowledge to answer research questions. Therefore, each case should offer a different view of the topic.

- Accordingly, each case must provide robust evidence and data to clarify the corporate and safety crime/harm phenomenon in the UK. The criteria for case selection will make it possible to identify similarities and differences in the implemented justice practice and actions on corporate offending. Chapter 5 helped me determine five different investigation and punishment results of WRDs. These findings led me to choose two case studies from these five different results: 1) Cases under corporate manslaughter law; 2) 'No information' and 'no further information on court process' cases; 3) Cases under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (inquest process and verdicts) determined throughout Chapter 5.

The cases can be examined by identifying the similarity and the uniqueness (Stake, 2003). Stake (2003, p.140-141) proposes several features to analyse cases: 'the nature and historical background of the case, other contexts (e.g., economic, political, legal and aesthetic), the physical setting and those informants through whom the case can be known'. In the light of this discussion, some critical features of cases (apart from the three main criteria) guide the case selection process.

In the first detailed case, the corporate criminal law was successfully applied in the same way as a street-level criminal investigation. Nikolai Valkov died in hospital after falling through the roof of a warehouse in Harlow on 13 April 2015. The inquest into the death represents one of the common characteristics of punished cases which involves small companies. These companies are easily punished as mentioned in the literature (see Hébert, Bittle and Tombs, 2019; Tombs, 2018). Second, the MNS Mining (Gleision Colliery) tragedy includes a particular feature in that there was no guilty company even though there were deaths and injured individuals, which is one of the fundamental reasons for selecting this case. The second distinctive characteristic of the Gleision Colliery case is that many different people, such as the police, the Crown Court, the Coal Industry Social Welfare Organisation, and experts, were involved in the prosecution process. This case is expected to provide several pieces of data related to corporate crime. For instance, it enables us to examine the 'senior management test' within a complicated case as discussed in the literature (See Herbert, Bittle and Tombs, 2019; Tombs, 2018).

The case study of 'The Crash of Valujet Flight 592: A Case Study In State-Corporate Crime (Matthews and Kauzlarich, 2000), helped me to determine the structures of two case studies. Matthews and Kauzlarich (2000) detail the following steps in preparing their case.

- the detail explanation of the background of the accident,
- the examination of regulation and laws in the relevant sector,
- the analysis of agencies related to the case,
- the analysis of factors and reasons lead to the accident, and
- the final step where the case was evaluated concerning 'motivation, opportunity, control and the interaction of the technical, organisational and structural dimensions of the crash' (Matthews and Kauzlarich, 2000, p. 294)

I followed these steps in my case studies, although there are some variations depending on the characteristics of the cases.

### 4.4.2 Vignettes

Covid-19 has negatively affected this research in various ways (see Section 4.6: Challenges and limitations). To reach interviewees and gain detail information from agencies took much more time than before the pandemic and was more difficult. To overcome these problems, I decided to use vignettes instead of detailed case studies and interviews.

Apart from the conditions which are negative effects of Covid-19 directed me to use vignettes, there are positive characteristics of crime vignettes guide this PhD thesis to employ it. The studies (analysed in 4.4.1.1) show the importance of investigating multiple examples of the prosecution process. This is one of the reasons behind using vignettes to investigate many vignettes rather than a smaller number of detailed case studies. Vignettes enabled me to analyse several instances of 'no information', accidental death, not guilty verdicts and convicted safety crime types.

Overwhelmingly, crime vignettes have been used by researchers to discern participants' approach to a particular topic (Aujla, 2020, Almond and Colover, 2010; Parton, Hansel and Stratton, 1991). Vignettes have also been used as helpful scenarios in qualitative research in criminology (Aujla, 2020, Almond and Colover, 2010, Parton, Hansel and Stratton, 1991). Adopted vignettes are used as helpful narratives in this thesis, they are used as an independent method of qualitative data analysis. Vignettes are used to examine agencies' approaches to WRDs and the results of their investigation and punishment processes. They are used as a unit of observation in this thesis. Crime vignettes can be used as an effective data analysis method. Kesselring (2020, p.4) explains the vignette as a 'social situation that subsequently offers an analysis and theorisation'. The

vignette can represent various situations and provide different narratives for readers. I have used vignettes to determine the patterns of different investigation and punishment results.

#### 4.4.2.1 Vignette selection

Kesselring (2020) suggests an important selection process to use vignettes in analysis. This is explained in Chapters 5 and 8 and in this section. I selected vignettes according to three particular rationales:

- ***(i)*** Chapter 5 helps to determine one of rationales. There are five main investigation and punishment types (see, Section 4.1). The first is analysed by Case Study 1 (see Chapter 6) and Case Study 2 (see Chapter 7). Therefore, vignettes are chosen from four main groups (2, 3, 4 and 5). In other words, case studies analysed cases under the CMCH Act (guilty and not guilty decision of corporate manslaughter while vignettes examined the other investigation and punishment types.
- ***(ii)*** The vignettes all happened between 2008 and 2016, and their prosecution processes were completed.
- ***(iii)*** The vignettes reflect (as much as possible) illustrative characteristics of WRDs' investigation and prosecution processes.

Vignettes enabled me to analyse more non-punished instances. Even so, the majority of the vignettes consisted of unpunished and non-prosecuted cases. Vignette analysis relies on the analysis of several documents, such as coroner's and sheriff's reports, court documents, mass and local media outputs and agency reports. Bowen (2009, pp. 27-28) identifies the sources of document analysis, some of which have been used in this research – for instance, 'meetings', 'newspapers', and 'organisational' or 'institutional' reports; survey data; and various public records. Investigating a complicated phenomenon needs comprehensive knowledge to justify the study's inclusion and appropriate design to allow the research questions and aims to be addressed. Crime vignettes have been analysed through documentary analysis.

### 4.4.3 Documentary analysis

Documentary analysis is a suitable social research method (Bryman; 2012; Bowen, 2009). Researchers employ document analysis in their study rely on mixed methodology (Bowen, 2009). Bohnsack (2010) emphasises the importance of documentary analysis to understand how the case or event under study happened in the light of participants' views. The various sources (see, the

section *Types of data: records and data*) in this research provided information that was valuable in understanding actors' perceptions. Accordingly, I placed emphasis on original discourses from documents and occasionally interviews, and then evaluated them. In addition, I paid attention to different views to increase 'sincerity' and 'credibility' of this research. It is one of the important strategies to overcome bias problem in research (Bowen, 2009). Moreover, documentary analysis provides advantageous for researcher regarding the triangulation (Bowen, 2009). Documentary analysis is employed together with the case studies and vignettes in this thesis. Spoken and written documentary materials reflected the agencies' approach to work-related corporate offending. I aimed to explore the characteristics of the police and non-police agencies' perceptions of, and approaches to, WRDs: one represents applied written criminal justice; the second represents what occurs in practice and may indicate different insights.

### 4.4.4 Statistical analysis

This section explains the fundamental data analysis method (Statistical analysis) applied in the thesis. Data analysis sources, such as HSE records and mass and local-media output, are the relevant data sources. I analysed these various sources mainly using graphs and figures to present a comprehensive view of applied justice and institutions' role in the inquest and court process.

Statistics is an important and appropriate method of analysis for this study. The analytic approach provides comparative information through numbers which can be compared with case studies and vignettes' findings. The changing view of criminal justice can be observed over years. The mixed methodology allowed descriptive statistics to be obtained.

Denzin and Lincoln (2003) argue that qualitative research does not require the use of only one particular method; the researcher can apply various methods such as content and discourse and document analysis and statistics. Weisburd and Britt (2014) state that using statistics on studies related to the offence and the criminal justice system is inevitable and crucial. Accordingly, statistical research helped me analyse the phenomenon of corporate offences. Statistics on work-related deaths embody the process of prosecution and investigation of the corporate offence. The literature review has indicated the importance of the HSE records. Many scholars (Hébert, Bittle and Tombs, 2019; Roper, 2018; Tombs, 2018; Tombs and Whyte, 2007) have drawn attention to work-related deaths and records of work-related deaths in their research to reify the corporate offending problem in the UK.

Descriptive statistics, derived from media and documentary research, were visualised by using graphs and tables, which enabled the results to be presented in a rigorous and scientifically effective way (Goggin and Best, 2013). One of the pioneer researchers articulated the importance

of and need for the visualisation of findings in social science and proposed that the use of visual presentation in an academic paper can be considered a sign of a mature science (Latour, 1990). Moreover, Wheeler (2016) stressed the importance of tables and graphs in a wide range of topics when addressed by police and professionals in crime. The validity and importance of visual inscriptions are broadly accepted in social science as a delineating characteristic of scientific inquiry (Caissie, Goggin and Best, 2017; Goggin and Best 2013; Latour, 1990). Aware of the advantages and validity of using tables and graphs, I analysed collected descriptive statistics of work-related deaths using such techniques. Descriptive statistics of workplace deaths enabled the researcher to determine key patterns of safety crime policing from 2008 to 2016. For instance, the numbers of investigated, punished and unpunished cases and further information were indicated by visualised statistics. In total, 759 WRDs cases were included in this research.

Beyond the statistical inscription of workplace deaths, they are indicators of corporate offences; for instance, the CMCH Act covers these deaths. The data from these cases helped me choose unique cases (the Koseoglu and Ozdil case, and the MNS Mining case) and vignettes to understand the investigation and punishment process since the CMCH Act 2007 was enacted.

#### 4.4.4.1 The process of analysis

This analysis relies on workplace deaths as listed in the HSE records (Health and Safety Executive, 2019). Firstly, statistical analysis was based on a case search using online search engines such as Google, Bing and Yandex. A point to consider is the choice of words put in the search engine, which directly affects the search engine's results. For example, when I did not achieve a result about a case with general research words such as the name of the deceased, I used the location and year of the accident. If this did not help, I used the company's name or sector, such as 'Glasgow construction company fined' or 'building worker killed in Glasgow' and the year. When I could find no information about a case, I extended the search to the Scottish Courts and Tribunals or Courts and Tribunals Judiciary and LexisNexis Quicklaw. I mostly relied on more credible websites such as the BBC, *Guardian*, the HSE, 'Scottish Courts and Tribunals' and 'Courts and Tribunals Judiciary'. However, if the media paid less attention to the case, I probed local newspapers and websites. One of the difficulties of researching work-related deaths is that sometimes the verdict changes for various reasons. I needed to double-check and confirm data for cases of this kind. Furthermore, I gained information from the HSE about 17 cases via Freedom of Information requests, and even though the data released by the HSE mostly coincided with the data presented in the thesis, I updated the collected data.

I checked convicted cases published on the HSE's official websites, accessing many convicted cases from this source for each year. When I could find no information, I used Lexis as a source; this applied to approximately 100 cases (particularly 'no information' cases).

I checked information about each case from multiple sources. Although this took more time, it made my research more reliable.

For my analysis, I researched workplace deaths of employees and those employed by others, but did not include the deaths of members of the public. One reason for this was that, due to time restrictions, the database had to be limited in size. The second reason was that less information on the investigation and prosecution of cases involving deaths of members of the public is available compared with worker fatalities. A third reason was that Tombs and Whyte (2007) criticised the reliability and usefulness of the HSE's statistics. Even though the data of self-employees and members of the public can be accepted as an important part of safety crime instances, the accuracy and availability of the information about the prosecution process are likely to be limited. Therefore, I restricted the analysis to employees and those employed by others.

### 4.4.5 Data analysis technology

I used NVivo, a computer-assisted qualitative data analysis software (CAQDAS), to organise the data obtained and facilitate the analysis process. NVivo is essential for coding and managing data and themes, creates a web between codes and a vast amount of data (Castleberry and Nolenb, 2018) and allows the writing-up and data analysis process to be carried out in a more reliable and manageable way (Castleberry and Nolenb, 2018). I used NVivo in case study analysis of discourses consisting of court hearings and agency reports. I divided court documents into three main themes: (i) background; (ii) the role of agencies and third parties); and (iii) court prosecution. Sub-categories included the HSE's role, collected evidence and the history of events connected to the accident. I used NVivo's 'Text Search Query' tool to indicate difficulties and uncertainty in the court prosecution process, particularly as placed in Chapter 7 (Case 2).

Despite the many advantageous of NVivo, its sole application may lead to limited analysis, –by fragmenting text, NVivo makes it harder to grasp the whole picture. For this reason, I evaluated whole texts several times.

## 4.5 Ethical considerations

The primary ethical consideration in this research was related to anonymisation and confidentiality. Anonymisation is crucial in social research based on qualitative methodology, but

it is occasionally difficult to sustain anonymity and confidentiality due to the nature of the study and the sensitivity of the research (Surmiak, 2018; 2020). Sometimes, the participants have already become known to the public via news, magazine and research papers. In these cases it was only possible to ensure partial, rather than comprehensive, anonymity. It is clear that ethical considerations are a fundamental issue in any research study. I obtained the required approval from the Ethics Committee of the University of Southampton. I proposed an amendment to change the data collection process to use PIS in all cases and interview participants regardless of cases. This was accepted.

I generated several strategies to maximise confidentiality rather than aim for complete anonymity. I was always honest with the participants. I explained the difficulties related to anonymity. I used codes and avoided direct quotes when informants asked for this. I presented three options for participants in the consent form: partial anonymisation, higher-level anonymisation and full disclosure. The first option allowed me to use participants' responses in reports, thesis and related publications together with their identities. The second option brought in a certain level of anonymisation. If a participant chose this option, I was authorised to use their words without publishing their name, status or job title. The last option offered the highest level of anonymity achievable for those interviewed in this research. I guaranteed to codify participants' identity so that readers of the report would not be able to trace the information they provided back to them.

Additionally, an assurance of anonymity can be sustained by excluding direct quotations from the final thesis made public as well as any related publications. In the first case, interviewees' statements will be put into an appendix at the end of the thesis, and in this way, the thesis will be restricted from public view depending on participant's choice. Participation Information Sheet (PIS) and Consent Form that was written separately based on the nature of the research design will be distributed among the participants before the field study to help them understand the purpose of the research and obtain their consent to participate.

Furthermore, I generated a Post-Interview Form. I have discussed the anonymity with my participants through the Post-Interview Form. On this, participants could give their thoughts on how their responses would be used in the research placed in the Post-Interview Form.

This study used in-depth interviews with key governmental and non-governmental agency members – police, CPS, HSE, local authority inspectors and other participants who had knowledge and experience of prosecution and court processes in fatal workplace injuries. I planned to conduct in-depth interviews with such individuals as far as possible. I spent a considerable time (seven months) to provide anonymity and confidentiality and obtain ethical approval.

Unfortunately, I could not conduct many of these interviews even though I tried many approaches.

## 4.6 Challenges and limitations

My original plan was to apply four detailed case studies relying on interviews and documentary analysis. My aim was to obtain data about the investigation process to which they were subjected by holding semi-structured interviews with key individuals and agencies. This ontological approach was appropriate to the research aim, which is to garner personal experiences and interpret the 'lived experience'. Covid-19 severely limited my ability to carry out this initial research plan because face-to-face fieldwork was curtailed. The pandemic restrictions posed three fundamental challenges for this research project.

The quality and quantity of data on corporate crime can affect research findings (Benson, Kennedy and Logan, 2016; Baldwin, 2000). It is challenging to study corporate crime for various reasons, such as access to reliable and proper data, and to participants (Whyte, 2000). Baldwin (2000, p.237) states that 'More serious still, judges, lawyers and other court personnel have proved in the past to be almost uniquely resistant to social research.' In working on this thesis, I faced similar difficulties. For instance, it was difficult to access the CPS and the police, even though I took several actions to overcome this problem. I tried to reach the CPS and police by email, phone and social media. Even though my project was described on the website of the College of Policing, many of my requests were denied or unanswered. For instance, the CPS denied my request to interview inspectors. Thus, I involved various data sources such as the records of the HSE, news, magazines and official records. Accordingly, the statistical analysis of the data and the documentary analysis of sources throughout the case studies and vignettes became primary methodological approaches; the research did not rely on interviews in this research.

The second challenge was to obtain approval, and this took more time than expected due to the uniqueness of the cases in terms of confidentiality, the sensitivity of the topic and the challenging restrictions due to the pandemic. The anonymisation of any participant is limited due to the public nature of the study; participants' identities are publicly identifiable from news reports and journal papers. I took some measures (as discussed in the previous section) to provide confidentiality and anonymity, which may have put limits on the analysis and presentation of the findings. Ensuring the highest level of confidentiality for participants may have resulted in some information being unused. In cases where the participants did not allow me to use their identities in the thesis and further publications, I could not freely analyse the findings, which may have led

to limitations such as emphasising the central actors' role and background information about the case. I tried to get participants' permission to use their identities in the report and further publications. I also prepared a post-interview form to allow me to use participants' direct speech as much as possible and to provide confidentiality for them.

I prioritised interview responses by analysing the general discourses related to corporate offending regardless of specific case characteristics. For instance, I analysed the information given by members of the agencies regarding unsuccessful investigations and prosecutions without mentioning the facts of the case in question. It is by this method that I hope to explain the central problem of this thesis accurately.

Covid-19 restrictions made the fieldwork difficult in several ways. Informants may have been more stressed and less responsive to requests than normal. Face-to-face interviews became impossible other than through video platforms. Approaching agencies became more difficult because many staff were working from home, and their priorities changed. Getting a response from participants took much longer than expected. These difficulties forced me to change the main methods from interviews to statistical analysis and documentary analysis of sources.

As well as published documents, I obtained some information from agencies about the prosecution and punishment process of workplace deaths through freedom of information requests and email.

The next chapter is the first data analysis chapter focuses on the statistical analysis of the investigation and punishment process (IPP) of WRDs. Chapter 5 examines various investigation and punishment results, the role of agencies in these processes and factors affecting the result of IPP of WRDs.

# Chapter 5 Varieties of Investigations: Statistical Analysis

## 5.1 Introduction

This chapter outlines critical findings gained from analysis of Health and Safety Executive (HSE) records and online documents (for further information, see Chapter 4) about work-related deaths (WRDs), their inquests and the court process. The chapter is divided into three main sections:

1) Statistics by years

2) The role of institutions and the implementation of justice

    a) the investigation and prosecution processes.
    b) punishment

3) Comparison of 8 years period (2008-2016)

The critical question is why it is essential to research WRDs considering differences in the implementation of corporate wrongdoing prosecutions and court processes within the UK criminal justice system. Let me begin by explaining the importance of WRDs in terms of corporate crime research. WRDs can be seen as potential corporate manslaughter and safety crime cases since workers die due to ignorance and irresponsible acts (see Chapter 3). Furthermore, as WRD records reflect a large number of deaths year by year, they show the importance of corporate manslaughter and safety crimes. Another important element of this chapter is that there has not been a recent study in the criminology literature that analyses the investigation and punishment processes (IPP) of WRDs using various data sources, such as the HSE's statistics, court and judiciary records, and mass and local media output. There are two similar studies (for further information, see Arewa et al., 2018), which was conducted by engineering scholars, but it relied on HSE statistics and focused on the applied punishment and applied health-and-safety regulations. Another similar study was published 15 years ago by Tombs and Whyte (2007), and this helped the research project in various ways (see Chapter 3).

The analysis of the periods consists of two main aspects: statistics and cases. First, the critical statistics, such as secured and unsecured cases, the number of different punishments and the conclusion of cases according to acts, are explained. The statistics are presented in graphs and tables to visualise safety crime policing in the UK. Secondly, significant cases are analysed to identify the characteristics of work-related corporate crimes. The analysis of cases provides insights that indicate the reasons and conditions for the low number of convicted corporate manslaughter cases. This statistical research provides an empirical foundation by providing a precise picture of the criminal justice system with regard to safety crime and by presenting

appropriate case instances. The analysis will enable us to determine the criteria for illustrative vignettes and the selection of case studies.

I researched the HSE's workplace death records and divided the key features of WRDs into five categories: 1) Cases under corporate manslaughter law; 2) 'No information' and 'no further information on court processes' cases; 3) Cases under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (inquest process and verdicts) regarding the result of the investigation and punishment process. Taken together, the findings covering these five categories provide the answers to the research questions.

Once statistics rely on clear and detailed information, they become more reliable (Weisburd and Britt, 2014). I have prepared two types of graph to display the acquired data: one presents the data that include the general numbers related to the prosecution and investigation processes, while the other displays more detailed information, including the last decision made by police agencies at the court. The descriptive statistics cover the eight-year period 2008-2016. I determined 2008 as the starting point and 2016 as a final point for several reasons. I had to determine a starting date between 1999 and 2022 (the period covered by HSE's records) and 2008 is close to the middle of that period. Importantly, the Corporate Manslaughter and Corporate Homicide Act came into force in April 2008, and I used data distilled from the analysis of the record after April 2008 to reify precise knowledge to understand work-related corporate offending in the UK. The various outcomes derived from the data collection process enabled me to decide that 2016 should be the final year for the following reasons:

- I encountered a high number of 'no further information on court process' cases.
- A relatively high number of cases were concluded by 2021 and 2022.
- I found a few cases in which the court processes were not completed by January 2022.

### 5.1.1 Categories in the figures

The *'investigated'* category contains three types of cases: the first type covers those investigated by HSE staff and the police but not sent to a court, the second type covers those prosecuted and charged by a jury and the third type involves cases in which the jury ruled the case to be an accident. The statistics on prosecuted cases also include those cases that went to court, but I could not access any information concerning the verdicts. The 'investigated' figures do not reflect the cases investigated only by the HSE. In other words, these cases show that agencies did not open a criminal investigation.

The *'punished'* figure reflects all given court punishments under Health and Safety at Work etc. Act 1974 (HSW Act), the Fatal Accidents and Sudden Deaths Inquiry Act (FAI Act) and related regulations, the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH Act) and other criminal and civil law.

*FAI cases* refer the cases that (i) I could not reach information about court result of cases investigated under FAI (Act), (ii) cases resulted in not guilty, and (ii) cases fined in the Sheriff courts. Punished cases in these figures also analysed as safety crimes and/or punished cases under health and safety law and regulations.

*HSW Act cases* refer the cases that punished (exclude punished cases in the Sheriff courts) and unpunished cases under health and safety regulations by agencies.

The *'no information'* figure indicates the number of cases for which I could not access any information through mass media or official documents and websites.

Every statistical work has some errors and weaknesses (Weisburd and Britt, 2014). The research of these records contains some weaknesses, one of which concerns 'no information' and (partially) 'no further information on court process' cases. In some cases, I could not access any information associated with court results. In contrast, the investigative process of these cases might have been closed by agencies for reasons. Information about the deceased may give us essential hints. For instance, some of these deaths were generally caused by vehicle accidents. It is likely that these deaths were not considered essential to get the attention of agencies and the media. Two options may have caused this uncertainty. The first is that there is information, but I could not access it (this is less likely). The second option is that none of the agencies initiated a further criminal investigation or punishment for these cases because there was no suspicious situation or witnesses or there was insufficient evidence. Therefore, the agency closed the case.

*No further information on court process'* presents merely one type of case: those in which there was no result about punishment. Thus, 'no further information on court process' refers to cases investigated by the sheriff, police and HSE but where we could not access further information about the court or punishment process.

The *'verdict of accidental death'* figure presents the cases that resulted in an accidental death, death by misadventure, a narrative order, open verdicts, lawful and unlawful death. Accidental death decisions refer to a different (and separated) inquest process from criminal prosecution (Wells, 1991). However, these decisions are important in the determination of the reason that led to death (Wells, 1991). In some cases, these decisions may refer to a criminal intention such as unlawful killing, narrative verdict and misadventure (less likely) (Wells, 1991) contrary to lawful

killing or a decision identifies the reason that natural causes led to death. Slapper (1993) indicated that among different accidental death decisions, just unlawful killing verdict can be evaluated as a potential corporate manslaughter case by police agencies. This category is also important to understand the coroners' and corner courts' approach to the WRDs.

'Not guilty' decisions of corporate manslaughter and other safety crimes are presented separately on the graphs and figures. Similarly, 'Investigated but no punishment for safety crimes' figures represents not guilty decision of courts and crown censure orders. Additionally, a few cases (9) were investigated by the police or the HSE, but agencies did not send the cases to court or open further criminal investigations. Therefore, these cases can be categorised as unpunished in this thesis. I considered these figures as unpunished cases because police and non-police agencies did not punish any organisation at the end of the investigation process.

As a last point about the figures, I identified the IPP result of WRDs for each case. In other words, if there were four deaths and the result was 'not guilty' of corporate manslaughter (in one year period, such as in 2015-2016), it is counted as four 'not guilty' decisions of corporate manslaughter instead of one not guilty decision in the figures and tables.

## 5.2 The policing of safety crime from 2008 to 2009

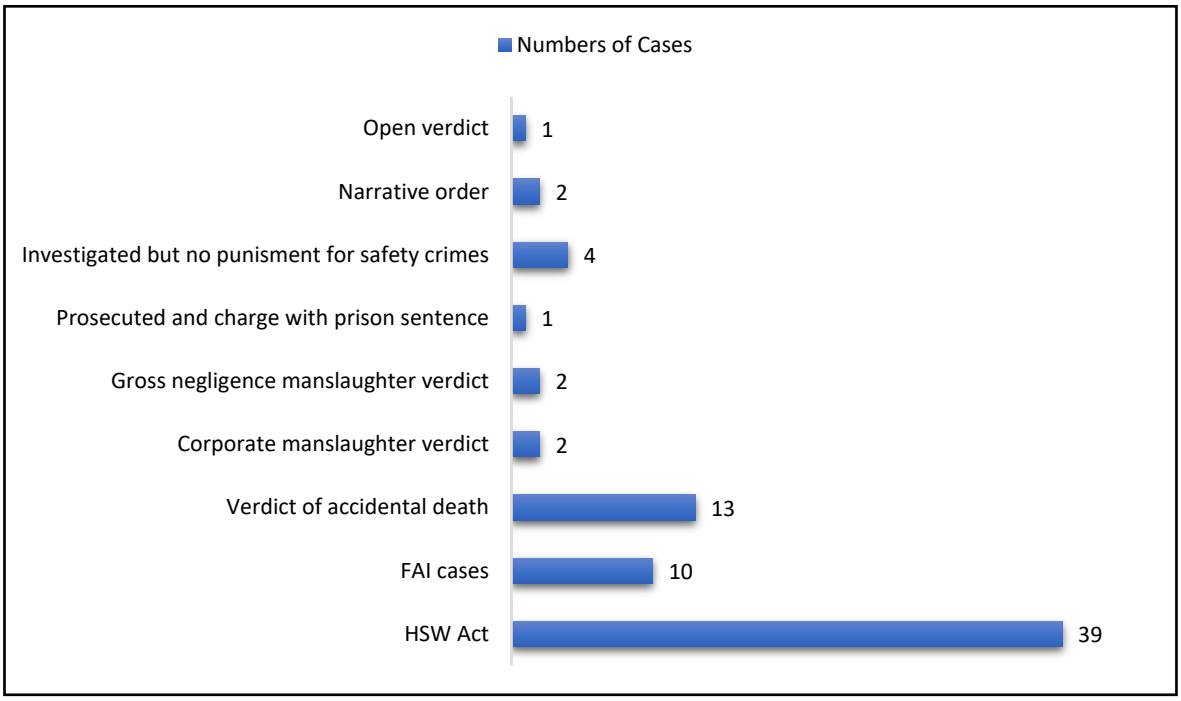



*Figure 5-1 The Response of the CJS to WRDs (2008–2009)*

***Figures 5.1*** and ***5.2*** present data about the inquest and court processes for those who lost their lives in the workplace in the 2008–2009 period. The recorded number of workers and civilians who lost their lives in this period was 234, 104 of whom were employees and employed by others. I focused on the deaths of employees and those employed by others.

Agencies closed the investigation process for two cases without sending them to the Crown Prosecution Service (CPS) or the court. In total four cases were not punished by court. HSE only gave notice for one (in the death of Radu Bors) of them while HSE did not take enforcement action for one (in the death of Raymond Chubb) of these cases. Some factors that are likely to affect the last decision (no punishment) of police non-police agencies are insufficient evidence, a lack of witnesses, agencies' perception and policy regarding the seriousness of wrongdoing.

The coroner or coroner courts deemed 13 of these cases accidental deaths in 2008–2009. This is equal to more than ten percent of all cases. The observation of these cases will be explained in the following sections to determine the characteristics of these cases. A noticeable pattern of accidental death verdicts is that technical failure or other conditions (according to agencies) lead to deaths (primarily in traffic and road crash accidents); therefore, most of these cases went unpunished due to recorded available sources The death of Michael Meehan represents one of these cases. Meehan was a worker who died in a road traffic accident in Bristol on the 28th of May 2008. The coroner articulated that the events resulted in a fatal injury:

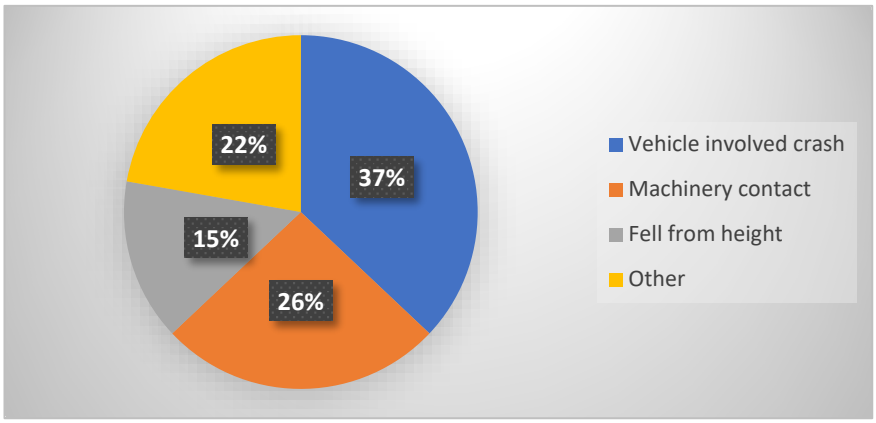
> What then happened tragically was that the JCB went out of control, crossed the outside carriageway and then crashed through the wall and fell onto the road below. The inquest heard that heavy rain left a large amount of surface water on the steep road. However, when Mr Meehan rounded a tight left bend, he was confronted by a line of stationary traffic and, knowing he could not stop in time, swerved out into the road. In a desperate attempt to halt his slide he lowered the front bucket of the digger on to the asphalt, but this caused his front wheels to lift and the brakes to lock up. Out of control and unable to steer he smashed over the kerb of the opposite pavement, through a stone wall and off the 100ft Avon Gorge, in Bristol (Daily Mail, 2009).

Agencies also indicated that they did not find any faults with the steering or braking in the digger (BBC, 2009). It seems that the police agencies perceived the death to be the result of an accident that occurred naturally rather than because of the company or manager's negligence. Even though there would be a possibility of further criminal process (or concomitantly), I could not reach information of guilty decision of a court. Nevertheless, for many cases that I have found the information to be investigated only by coroners, it is crucial to place these decisions.

I could not access information about a relatively high number of deaths (26 out of 104). A likely explanation for this is that these cases' investigation processes were completed before being held in court. These cases refer to an unsuccessful prosecution process. The pie chart presents the reasons that led to accidents according to the HSE's record. In some of these cases, the agencies

may have considered the circumstances that led to deaths as natural causes and did not see the suspicious circumstances necessary to open a criminal investigation. However, it should be noted that this explanation is partial. To reach a strong argument, further analysis of cases is required.

*Table 5-1 Common causes of death in no information cases*




For instance, the reason for the death of Christopher Waite was determined by the HSE, who said, 'The deceased died of asphyxia and inhalation of food' (The National Archives, 2020).

Most punished cases (42 out of 46) were described as health and safety crimes. Ten cases (five of them was punished) were investigated by a sheriff and/or Sheriff courts under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act. This shows that the HSE and police paid close attention to WRDs. However, police agencies gave prison sentence for merely 1 of 46 cases (in death of Kenneth Joyce).

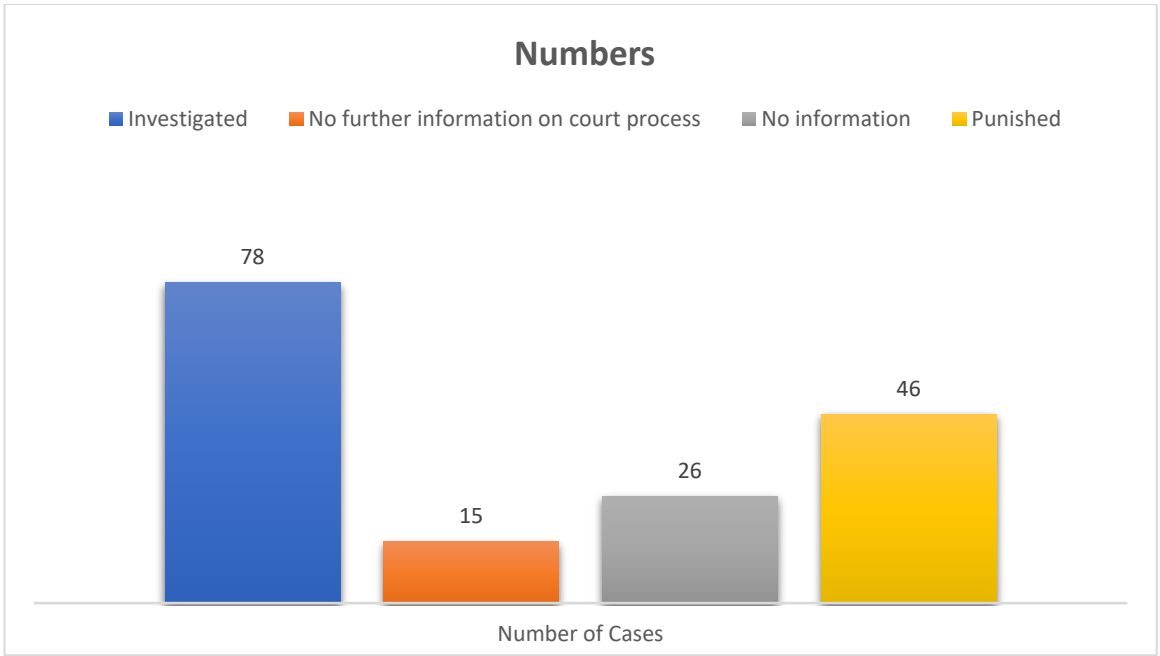


*Figure 5-2 IPP as a Result of WRDs (2008-2009)*

The observations derived from the data collection process suggest that convicted cases under health and safety regulations show particular characteristics. One of these is that non-police agencies evaluated these cases and deemed them avoidable. Importantly, police agencies found that a failure or irresponsible act led to these deaths. To illustrate, in the prosecution of the death of Juan Romero, the HSE considered the accident to be 'wholly avoidable' (BBC, 2013a).

Further, even though the CMCH Act was only established this year, two cases resulted in corporate manslaughter. A similar result can be observed in the gross negligence manslaughter figure, as the CPS and court considered two cases to be gross negligence manslaughter. In this case (the death of Kenneth Joyce), the CPS stated that 'Mr Joyce's death could have been "easily prevented" if a "safe system" of work had been in place' (BBC, 2013b). The company was also punished under health and safety regulations.

*Table 5-2 The values of fines (2008-2009)*

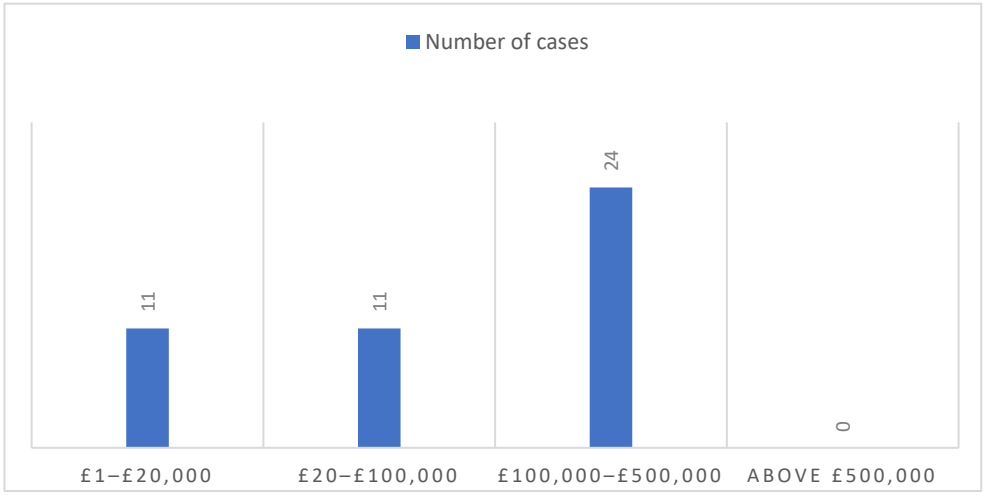



Table 5-2 indicates the number of cases in which the courts handed down fines on conviction; the penalties are divided into categories. The table indicates that judges punished most companies and individuals with fines that increased from £100,000 to £500,000 between 2008 and 2009. It is difficult to say police agencies applied severe punishments in this period. It can be observed that there were no fines above £500,000 and 11 cases resulted in small fines (see £1-£20,000).

Overall, statistical analysis of this period shows that crime-related agencies investigated a comparatively high number of cases. The courts handed down punishments for more than half of the investigated cases. The majority of cases were investigated and prosecuted. However, the companies involved in many WRDs were not prosecuted (26 out of 78) or punished (46 out of 78).

Accordingly, only two per cent of these cases were prosecuted within the scope of corporate manslaughter. In addition, 58 cases went unpunished in this period due to this thesis' research. Another pattern that emerged from this period is that police agencies resorted to various acts and regulations that applied to WRDs instead of single acts or regulations that applied to WRDs. Further, the cases resulted in not only guilty and not guilty verdicts but also accidental death, uncompleted and 'no further information on the court process' verdicts.

## 5.3 The policing of safety crime from 2009 to 2010

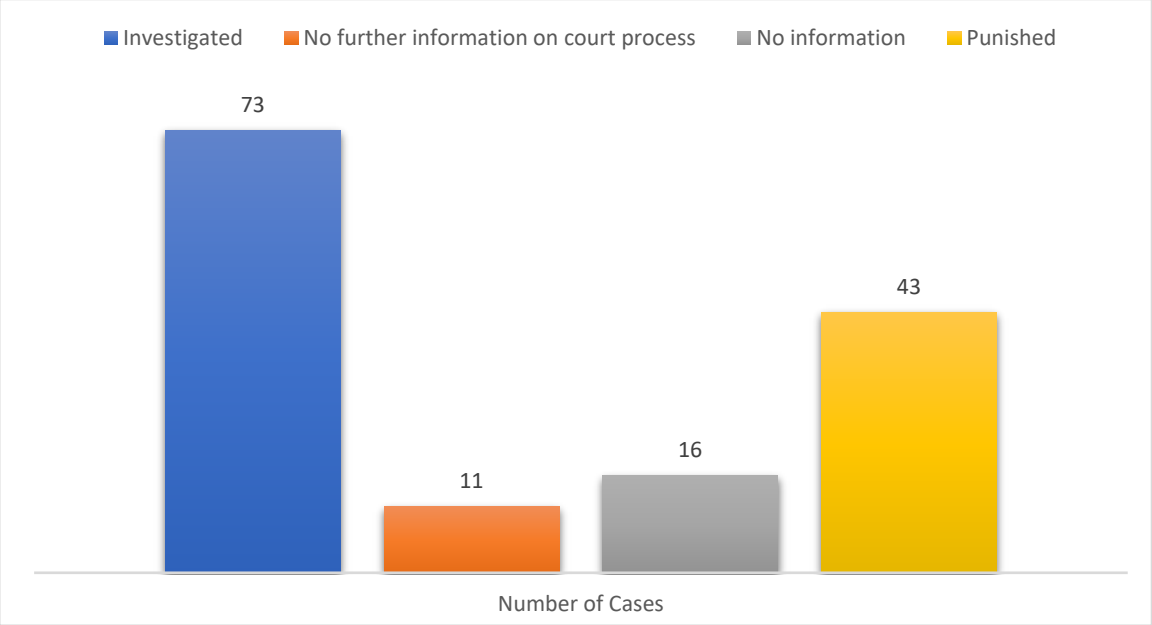



*Figure 5-3 IPP as a Results of WRDs (2009–2010)*

The total number of deaths, including employees, those employed by others, self-employed people and members of the public, was 178; however, I focused on the deaths of employees and those employed by others (89) in the period 2009–2010. The number of prosecuted and punished cases slightly decreased compared to the previous years (from 46 to 43).

*Table 5-3 Number of researched cases*

| Periods | Researched cases in numbers |
|---|---|
| 2008—2009 | 104 |
| 2009—2010 | 89 |
| 2010—2011 | 107 |
| 2011—2012 | 105 |
| 2012—2013 | 90 |

In this period, I investigated relatively few WRDs compared to the other four years, leading to an increase and decrease in some categories (see Table 5-3).

Additionally, there were fewer cases for which I could not access any information. It is necessary to state some details about the 'no information' cases. I mainly could not trace the cases that happened in the agriculture, transportation and hazardous waste sectors. The cases happened in the transportation sector; agencies do not carry out prosecution processes in such cases. Finding witnesses and gathering evidence might be more difficult in these kinds of cases due to the characteristics of the accident scene, taking into account the availability of CCTV and witnesses. A possible explanation is that the HSE did not investigate these cases due to their policy of investigating cases that occur in the most dangerous sectors. I will return to this issue in the following sections and in detail in Chapter 8.

Moreover, other reasons may have led to the investigation process being closed. Thus, I could not find qualified and detailed information about such deaths. For instance, Satpal Singh (a bus driver) died in a traffic accident when a bus hit another bus, and the driver injured his head (Express and Star, 2009). Of course, these arguments are only partial. To conduct more precise analysis, a larger number of cases should be shown to exhibit a similar pattern. Mathews, Fitzpatric and Philip Bohle (2014) paid attention to obfuscated investigation and prosecution processes for these kinds of deaths, since they are covered by various laws. Even though they examined the situation in different countries (New Zealand, Australia and the USA), the same results can likely be observed in the UK.

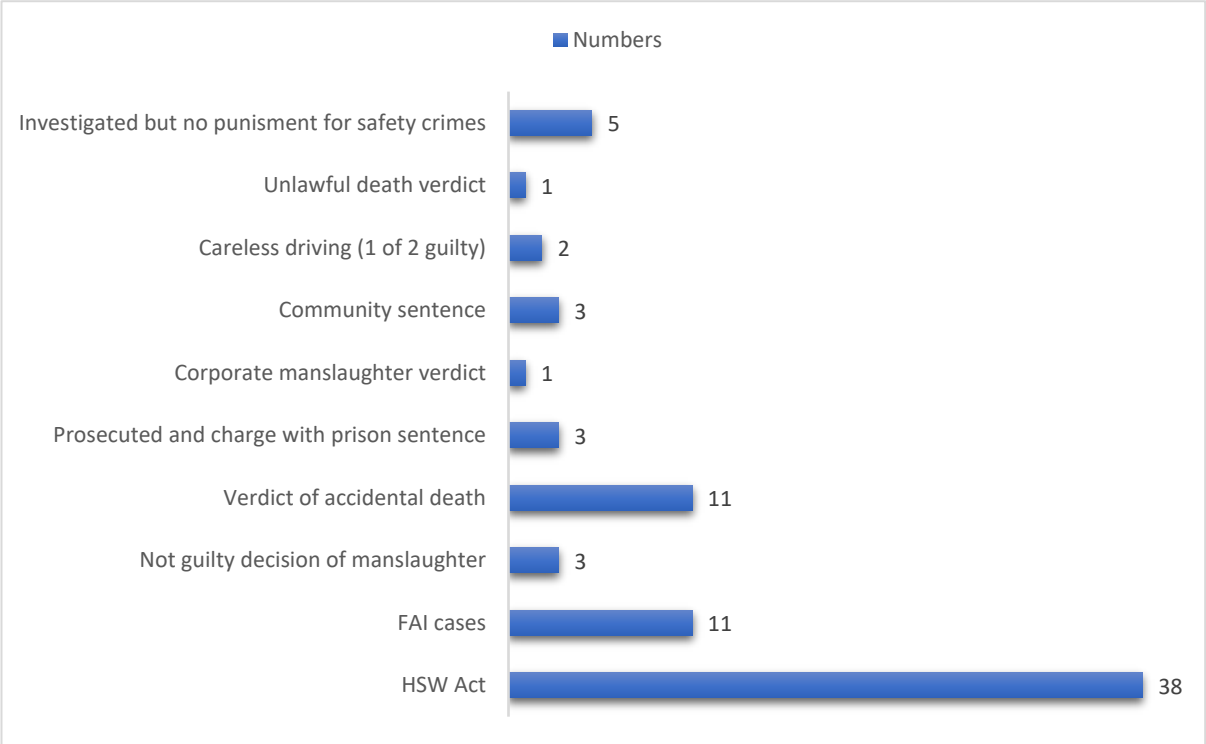



*Figure 5-4 The Response of the CJS to WRDs (2009–2010)*

***Figure 5.3*** indicates that the courts punished the majority of investigated cases (43 out of 70). Additionally, in one out of 43 cases were charged, Cavendish Masonry Limited was charged with corporate manslaughter, and six out of 70 cases were prosecuted under criminal law (see ***Figure 5.4***). Additionally, fewer cases went unpunished in this period compared to the previous year. Agencies closed the investigation process of one case without sending it to the police agencies.

One of the patterns in convicted health and safety cases is worth mentioning: having untrained staff is considered wrongdoing by police agencies. The deaths of Shaun Scurry (Services, 2013) and Kerry Daly (Safety and Health Practitioner, 2011) may be evaluated as illustrative examples in which agencies highlighted a lack of training and inadequate training as reasons that led to an incident during the court process.

During this period, the one of the most common verdicts (11 cases) was accidental death. The number of these verdicts shows the importance of accidental death verdicts in terms of occupying place within the whole picture (more than 10 per cent of all cases). I have also observed that very few accidental death verdicts were converted into convicted verdicts after a while. This will be analysed if this pattern is observed in the following periods.

The analysis shows that the figure for a verdict of accidental death is one of the reasons behind the low number of convicted corporate manslaughter cases. In other words, the coroner or coroner courts decided to give an accidental death verdict. It is observed that there has been

generally no conviction even after criminal prosecution due to this research. One of these cases may provide insights that help comprehend the importance of these cases. Denis Livesley died in Manchester on the 21st of December 2009 due to a road traffic accident. Initially, a jury returned a verdict of unlawful death in 2011; however, a year later, High Court in Manchester gave an accidental death verdict (BBC, 2012a). The discourses of agency members related to this case is explanatory regarding the importance of these cases. Judge considered that making a decision by jury about dangerous driving led to death is professionally not right (BBC, 2012a):

> The case was of general importance, the judges said, as it clarified the law relating to road deaths which they said was causing 'a divergence of view' among coroners and needed to be resolved. They said: 'The offences of causing death by dangerous driving, causing death by careless driving and other driving offences where death is caused do not fall within the scope of a verdict of unlawful killing in the coroner jurisdiction'.

Using insights gained from the narrative of this discourse and other similar cases, this study suggests, in the first place, that agencies struggle to evaluate these kinds of cases as corporate manslaughter cases due to the structure of regulations. Second, police agencies take into account 'public interest' once they consider a case. This can be observed in the discourse of Justice Foskett:

> The prospect of hundreds of cases each year being considered, by a coroner or a jury, as potential cases of unlawful killing because of some possible careless driving is alarming, would involve a disproportionate amount of time and expense and would take into the **inquest process something it is less well equipped to consider than either a criminal or civil court.** The judges also ruled a fresh inquest on Mr Livesley's death **was 'not in the public interest'** [author's emphasis] (BBC, 2012a).

*Table 5-4 The values of fines (2009-2010)*

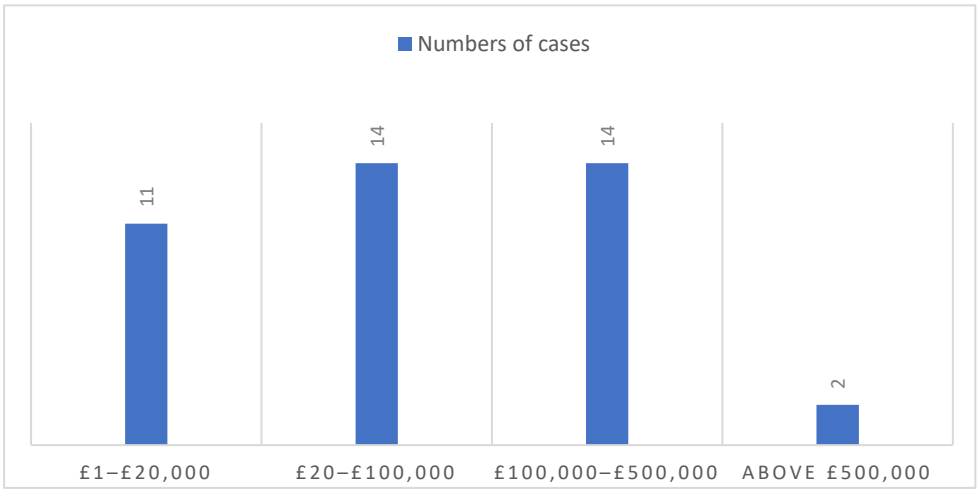



***Table 5-4*** indicates that police agencies punished companies and individuals with fines above £500,000 in only two cases. In comparison with the previous period, the table shows that there

was a sharp decrease in the number of cases penalised with fines between £100,000 and £500,000 (from 24 to 14). The amount of fines shows that police agencies took a soft approach to safety  crime. For instance, Manchester (Minshull St) Crown Court imposed a very low fine (£1) in one case: the death of Bruce Dempsey (Health and Safety Executive, 2013).

Analysis of the second period (2009–2010) indicates consistent patterns in treating WRDs within criminal justice systems. The first pattern emerged in the data analysis process, which enables us to categorise agencies' responses to WRDs under specific themes: 1) Cases prosecuted under corporate manslaughter law; 2) 'No information' and 'no further information on court processes' cases; 3) Cases investigated under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (the result of WRDs' inquest process).

The second pattern in this period is that police agencies mainly intended to charge companies under the HSW Act rather than corporate manslaughter. Given these trends, it has been argued that the police agencies applied various acts and regulations, and as an expected result, they gave different verdicts. In short, these empirical findings provide a starting point for analysing the characteristic results of WRDs, as they show the police's and non-police agencies' responses to work-related corporate offending.

## 5.4 The policing of safety crime from 2010 to 2011

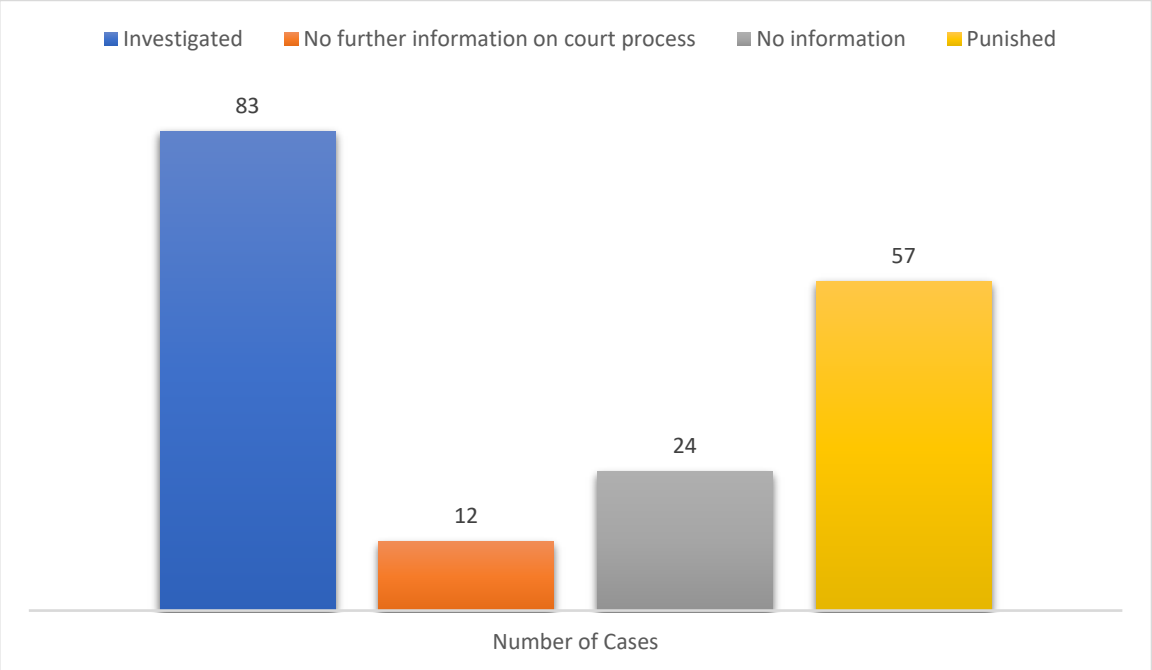



*Figure 5-5 IPP as a Result of WRDs (2010-2011)*

The total number of deaths that includes employees, those employed by others, self-employed people and members of the public is 211. The cases of 107 employees and those employed by others were researched for the 2010–2011 period.

The deaths about which I could not access sufficient information usually related to deaths caused by vehicle accidents. These 24 deaths happened as a result of the person being hit by a vehicle (seven workers), falling from a vehicle or height (six workers) or being crushed by a vehicle (eight workers) during the 2010–2011 period. The majority of these cases can be categorised under the transportation industry. This pattern was partially observed in the previous periods (2008–2009 and 2009–2010), which provides the grounds to establish an assumption that investigative difficulties, such as finding witnesses and evidence, as well as the conditions in the place the accident occurred, led to the inquest process for the case being closed and no further criminal investigation taking place. Furthermore, the agencies' approach, which perceived the reasons for these deaths as technical failures or natural causes instead of gross negligence on the part of companies, may have been effective in closing the prosecution process for the case.

Meanwhile, some cases have been excluded because they do not fit in with the dominant discourse that the media pays attention to cases involving well-known people. For example, an investigation was launched into the death of a relatively well-known Leicester city councillor (Philip Gordon) who died in 2010 (BBC, 2010a). However, there was no further information about the court process anywhere. Another example is the death of Gordon Brass, who was a soldier when he fell down. I could not find any further information, even though the Ministry of Defence was involved in the case (The Newsroom, 2010).

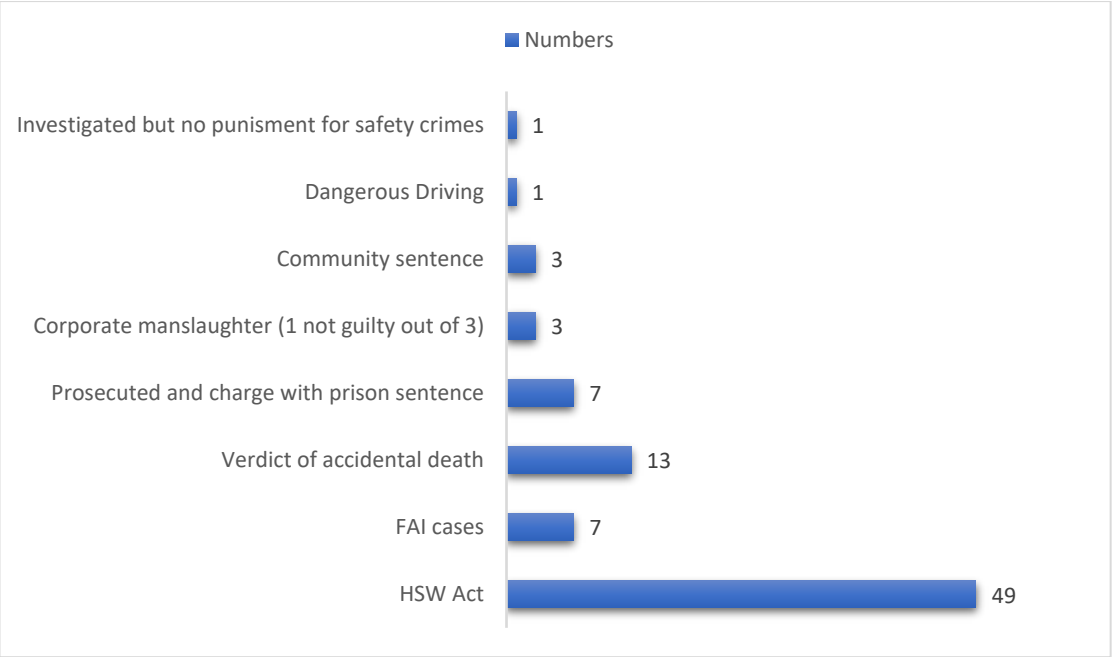



*Figure 5-6 The Response of CJS to WRDs (2010–2011)*

The remarkable figures in the 2010–2011 period refer to the number of punished cases. The courts punished a vast number of cases (57 out of 83 investigated cases). This finding enables us to argue that crime-related agencies effectively performed against WRDs compared to previous years. Additionally, many more people were punished with a prison sentence (7) than in previous years (3). Controversially, the smaller numbers of prison sentences given (7 out of 83) and corporate manslaughter convictions in two cases (2 out of 83) contribute to current criticism of safety crime policing (Hébert, Bittle and Tombs, 2019; Tombs; 2018; Almond and Colover, 2010).

The number of accidental verdicts is higher than the previous year. Similarly, the typical response of the government's legislative policy to WRDs is to define them as accidental deaths rather than crime considering high number of unpunished cases (50 out of 107).

A community sentence is not a widely preferred punishment type; it is an atypical pattern of safety crime policing even though 3 community work sentences were given till in this period. Notably, some company directors or owners were also killed at work, and the HSE and police also prosecuted these cases. This shows that not only workers are killed in the workplace but also owners or managers, and these cases can be prosecuted and result in punishment, which is evident in the case of Anthony Baines (Grimshaw, 2010).

A similar result can be observed in 2010–2011 as work-related corporate offending was mostly punished under health and safety regulations and laws. In addition, the court can give a prison sentence in these cases. This is evident in the deaths of Ian Middlemiss (McKewn, 2014), Adam Taylor, Peter Johnson, Tomas Hazelton and Daniel Hazelton, all of four were part of the same case

(Prior, 2017). The police agencies thought serious wrongdoing had led to the accident in this case and handed down prison sentences. However, they did not prosecute this case under the CMCH Act (Safety and Health Practicioner, 2014; Prior, 2017).

Two more corporate manslaughter convictions are not presented in the figures because the workers' deaths (Robert Wilson and Mari-Simon Cronje) were not included in the HSE's figures in this period. However, I included these exceptions in the total number of corporate manslaughter convictions placed under titles 5.10 and 5.11.

*Table 5-5 The values of fines (2010-2011)*


Tables 5-5 and 5-6 show that there have been considerable changes in the amount of fines compared to the previous period (2009-2010). An almost fifty per cent increase was observed in the penalty category, which ranged from £100,000 to £500,000. Additionally, a greater number of cases resulted in fines of more than £500,000 compared with previous years.

*Table 5-6 Summary of fines in three periods*

| The periods | Range of fines: Above £500,000 | Range of fines: £100,000-£500,000 |
|---|---|---|
| **2008-2009** | 0 | 24 |
| **2009-2010** | 2 | 14 |
| **2010-2011** | 5 | 26 |

These changes can be interpreted as a positive sign for safety crime policing.

Analysis of the period 2010–2011 also reveals patterns that can be observed in previous years:

- The investigation and court processes for WRDs can be categorised under five main themes: 1) cases investigated under the CMCH Act; 2) 'no information' and 'no further information on the court process' a; 3) cases investigated under the HSW Act; 4) gross negligence manslaughter; and 5) accidental death verdicts.
- Many companies went to court; however, they were prosecuted and punished under health and safety laws and regulations instead of corporate manslaughter.
- A very low number of cases resulted in prison sentences (7 out of 107).
- Police and non-police agencies leave considerable numbers of cases unpunished (57 out of 107).

## 5.5 The policing of safety crime from 2011 to 2012

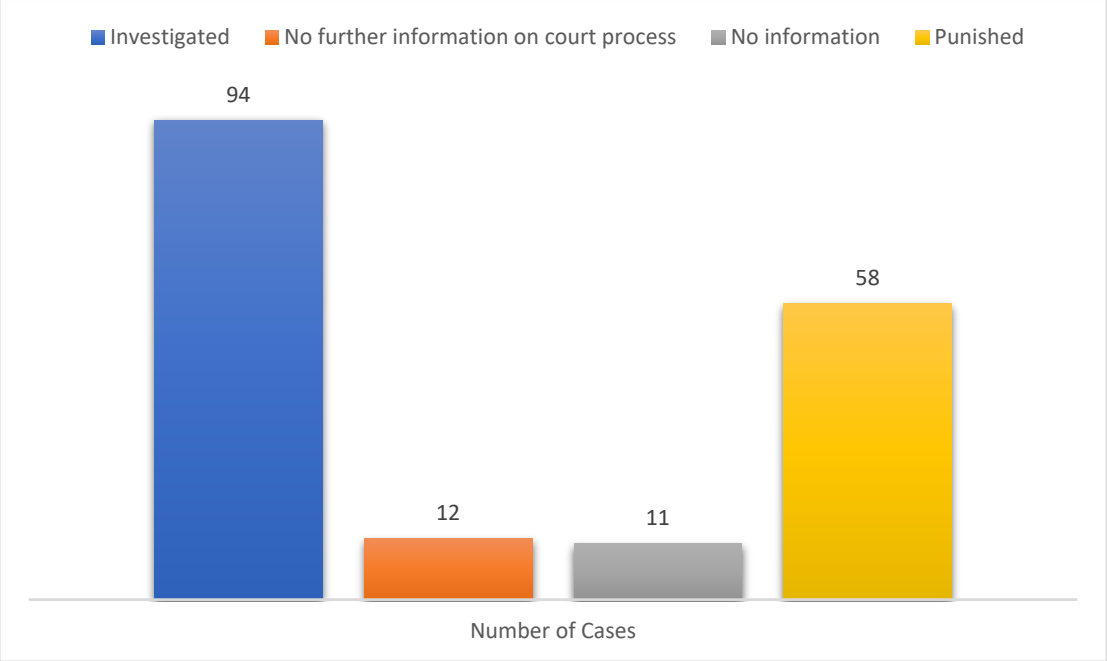
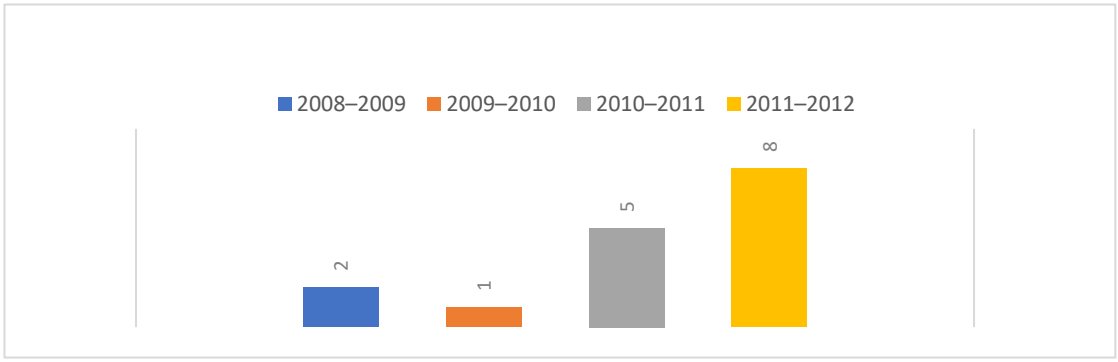



*Figure 5-7 IPP as a Result of WRDs (2011–2012)*

The total number of deaths that include employees, those employed by others, self-employed people and members of the public is 214. Only the deaths of employees and those employed by others (105 employees) were analysed in the 2011–2012 period.

***Figure 5.7*** shows that a relatively high number of cases went unpunished (47 out of 105). This may suggest the poor performance of agencies. However, more cases were prosecuted under the CHMC Act, which was the highest number in four years. This can be observed in Table 5-7.

*Table 5-7 Number of prosecuted cases under the CMCH Act*



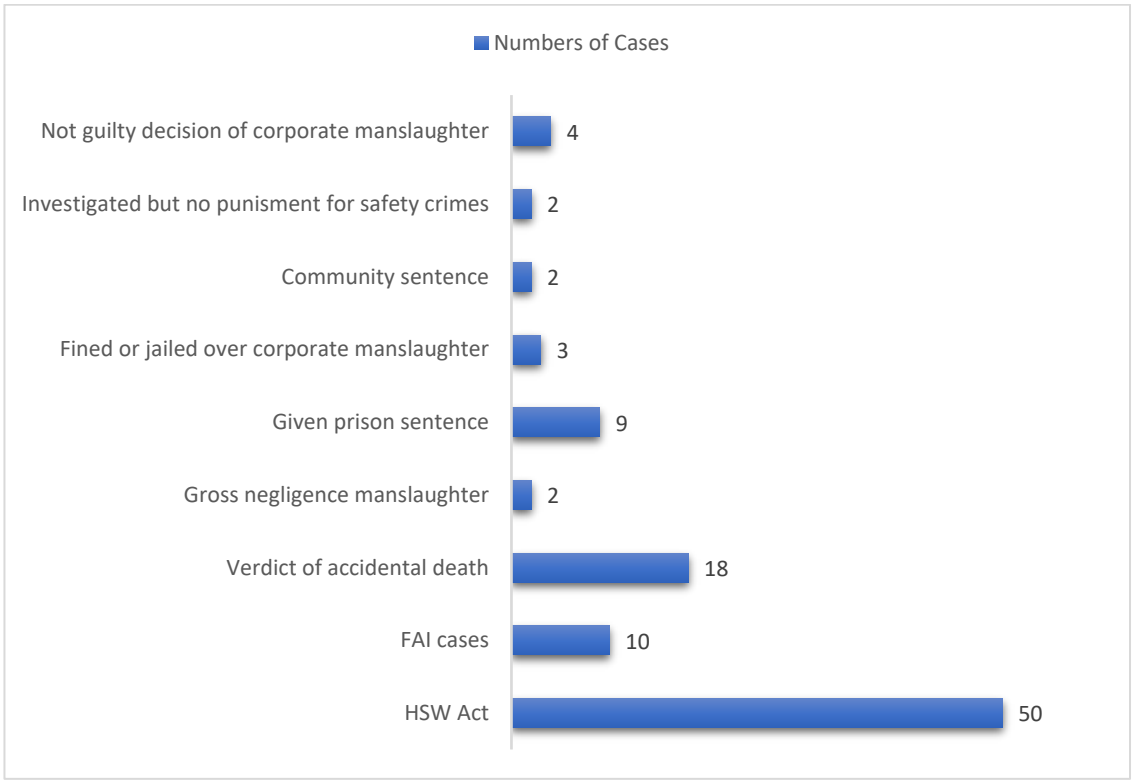




*Figure 5-8 The Response of the CJS to WRDs (2011–2012)*

***Figure 5.7*** indicates that I could not find any information about 11 cases, which is the lowest number over four years (2008–2012). From 2010 to 2012, there was a sharp decrease in the number of 'no information' cases. No information and no further information on court process figures refer that a smaller number of workers' deaths resulted in a prosecution process that did not include appearing in a court, or a smaller number of cases resulted in no one being punished. Five of the twelve 'no further information on court process' cases were investigated by a sheriff

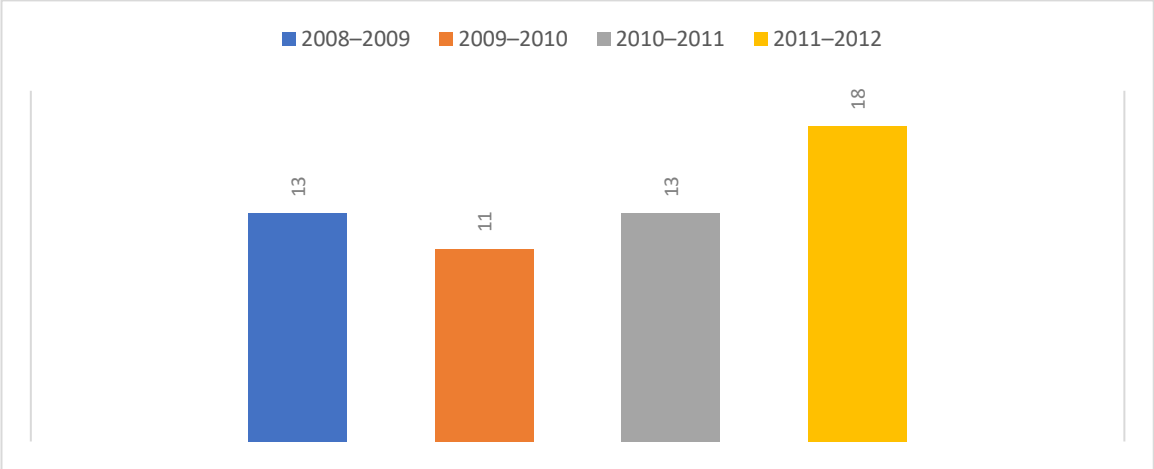
under the FAI Act. In one of these cases (the death of James Steele), Sheriff Ruth Anderson briefly indicated:

> There were no reasonable precautions which might have avoided his death. There were no defects in the system of working which contributed to the death. There are no facts which are relevant to the circumstances of the death (Anderson, 2012, p.2).

The evidence presented in the sheriff's report indicated that no one saw what happened when the accident occurred. This case can be evaluated as a supportive example that some 'no information' and 'no further information on court process' cases went unpunished, which suggests there were uncompleted prosecution processes because of difficulties in terms of finding witnesses and evidence and the condition of the place the accident occurred.

I observed that the highest number of accidental death verdicts (18 out of 105) in four years (2008–2012) was given in 2011–2012 (see Table 5-8).

***Table 5-8 Number of accidental death verdicts***




The death of Dominik Molak is an explanatory case, regarding accidental death verdicts, in terms of understanding the criminal justice system's approach to work-related corporate offending (which shows the role and approach of coroner and coroner courts). Molak died when a heavy metal casing fell on him. Chelmsford Coroner's Court's accidental death decision relied on the HSE's investigation, suggesting the company did not have an abysmal health and safety record or approach. The worker 'could not have known how much force it would have taken to have caused this to happen, as he was not an engineer' (Tilley, 2012). I encountered an response to accidental death cases: the coroner may share some concerns with third parties to prevent future deaths. This will be examined to determine if it is a pattern in the following periods. Furthermore, in this period, non-police agencies closed the investigation process for two cases (the deaths of Jonathan Kent and Anthony Bolt) without sending the cases to police agencies according to the response of

HSE to a Freedom of Information (FoI) request in August 2022. In one case (the death of Anthony Bolt), the HSE issued a prohibition notice (; therefore, I categorised this case as 'investigated but no punishment for safety crimes 'in the ***Figure 5.8***.

Even though some types of punishment were rarely given, their figures are continually observed each year. Police agencies gave one community order and, in addition to this, concluded that two cases were gross negligence manslaughter (see ***Figure 5.8***). The result of one case (the death of Norman Porter) needs to be mentioned here because agencies evaluated this case and deemed it corporate manslaughter (BBC, 2013c). However, the result of this case is not presented in the statistics for this period because it is not included in the HSE's record. I put this result in the total number of corporate manslaughter convictions presented under titles 5.10 and 5.11, and in the table 5.7 in this chapter.

### *Table 5-9 The values of fines (2011-2012)*

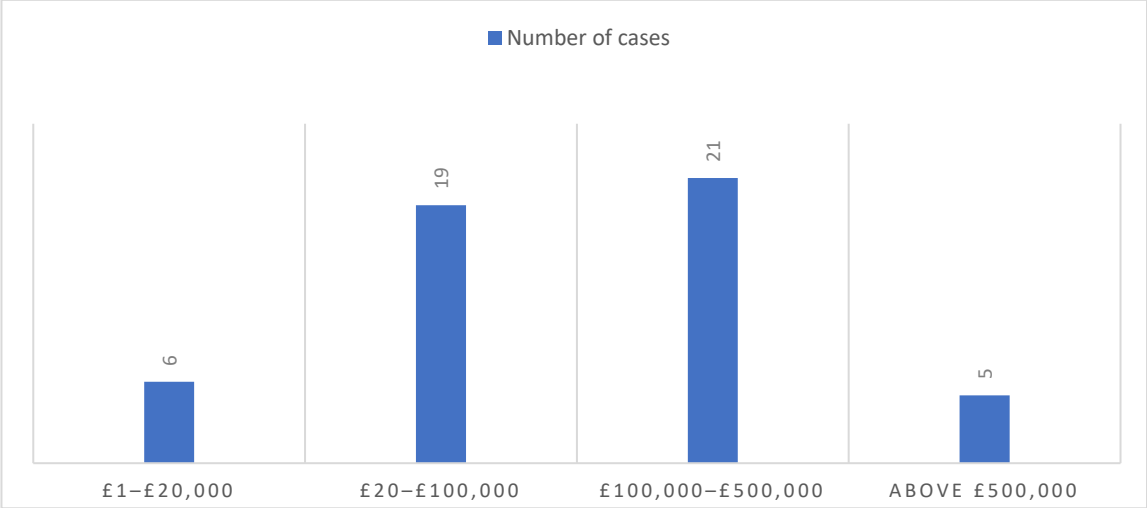



Table 5-9 reveals that judges imposed relatively large fines (i.e. above £500,000) in only five cases. More commonly, the court punished companies with fines ranging between £100,000 and £500,000. The graphs show that there was a steady decline in the number of cases in which the court imposed a small fine (£1-£20,000). The range of fines in 2011-2012 shows that there was not a marked increase or decrease compared to the previous period (2010-2011). It should be noted that if the same company was punished for multiple cases only one result was included in the table.

Most of the investigated cases (53 of 94) were punished under the HSW Act and other health and safety regulations instead of the CMCH Act. This pattern is critical to understanding how agencies have responded to corporate offending. These cases are not considered corporate manslaughter. For instance, one company was fined £5 million at Swansea Court (BBC, 2019a). Considering the proven failure of companies and the seriousness of harm (four workers died), police agencies

considered these deaths to be a crime due to health and safety regulations rather than corporate manslaughter (BBC, 2019a). This case will be examined further in the section titled 'The Role of Institutions and the Implementation of Justice'.

In conclusion, analysis of the period 2011–2012 shows similar patterns to previous periods:

- The investigation and court processes for WRDs are similarly categorised into five main types of results. Each type of result presents different narratives.
- Crime agencies investigated the majority of cases (94 out of 105).
- However, courts punished fewer investigated cases (58 out of 105).
- Additionally, police agencies preferred to apply health and safety acts rather than corporate criminal law to WRDs.

## 5.6 The policing of safety crime from 2012 to 2013

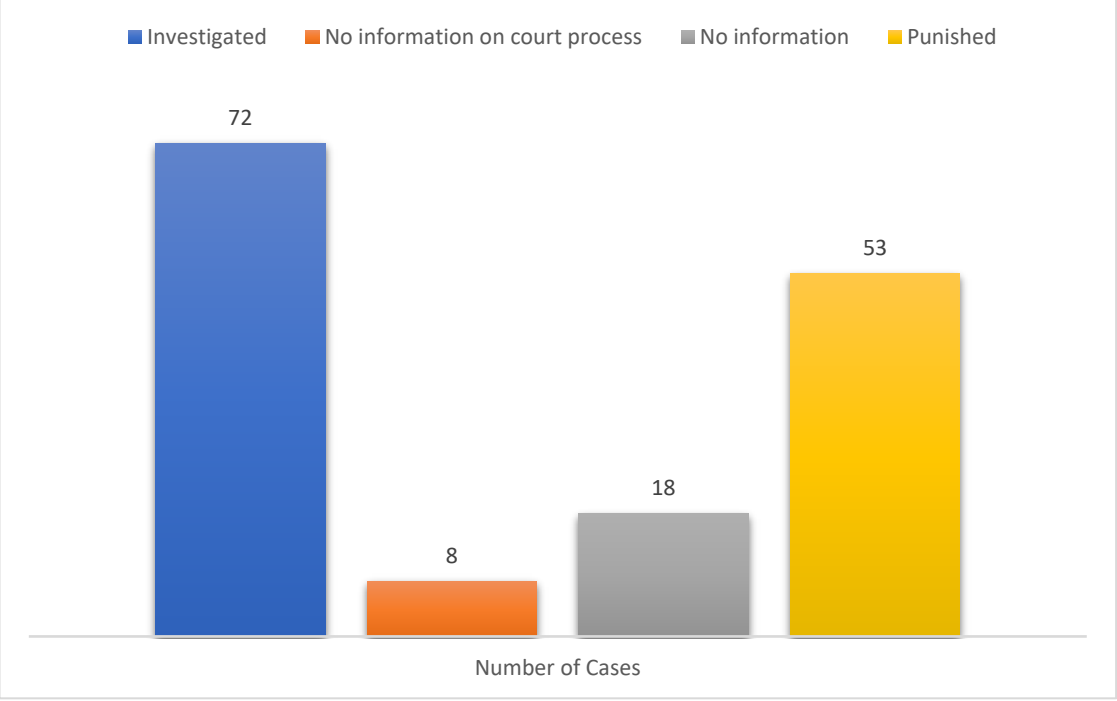



*Figure 5-9 IPP as a Result of WRDs (2012–2013)*

In 2012–2013, 148 people died in the workplace. I researched 90 cases out of 148, which included employees, those employed by others and trainees. Further statistics revealed that the lowest number of deaths from mid-2008 to mid-2013 happened in 2012–2013.

The data in ***Figure 5.9*** reveals the highest punishment rate (53 out of 73). This may refer to the high-performance level of agencies. Accordingly, 13 out of 53 cases were concluded with prison

sentences, even though most prison sentences (in 8 cases) were suspended. This is the highest number in five years.

However, most cases (45 out of 53) were perceived as violations of regulations instead of corporate manslaughter. Some of the reasons given, such as not guilty decisions and the existing number of not prosecuted cases, led to a low number of corporate manslaughter convictions. It should be noted that there were two more corporate manslaughter convictions, which are not presented in the figures because the workers' deaths (Peter Lenon and Ivy Atkin) were not included in the HSE's figures in this period. However, I included these exceptions in the total number of corporate manslaughter convictions placed under titles 5.10 and 5.11 in this chapter.

The agencies played a critical role in the last decision and in deciding whether a further inquest was necessary.

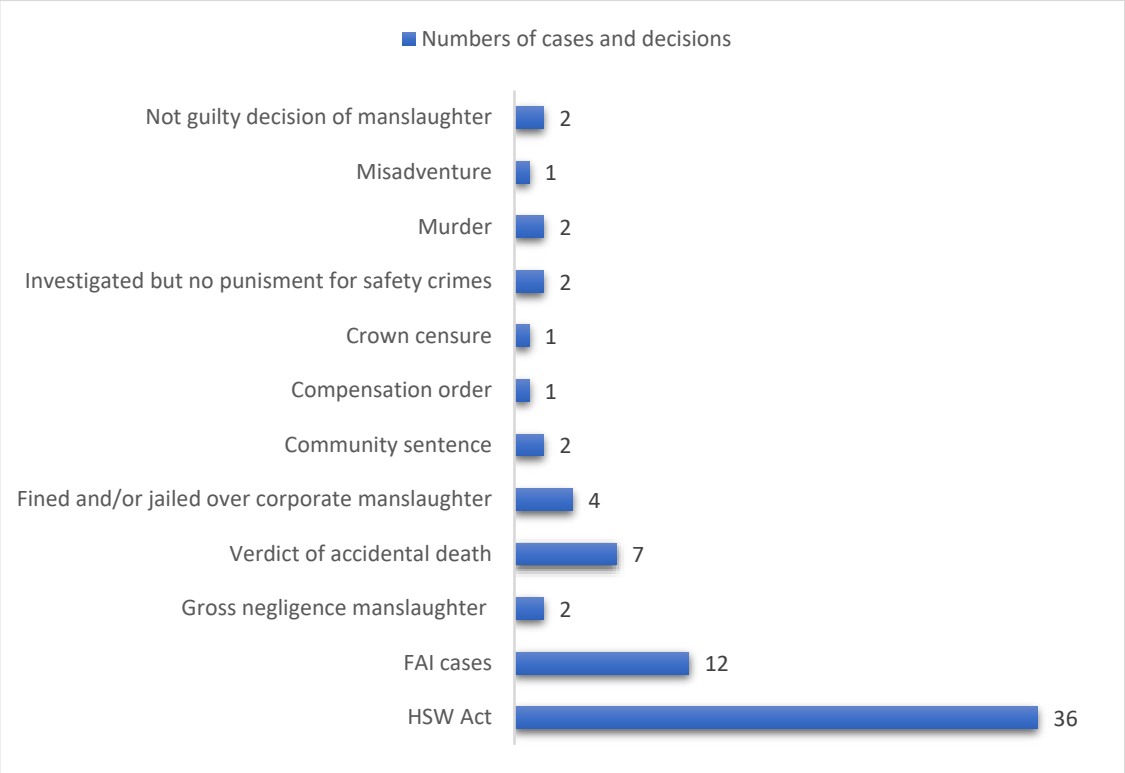



*Figure 5-10 The Response of the CJS to WRDs (2012-2013)*

Similar patterns emerged over the period 2012–2013 as most punished cases were those in which there was a conviction for violating the HSW Act and regulation. Statistical analysis might suggest that police agencies (the CPS and court) might not have been inclined to consider cases as corporate manslaughter or gross negligence manslaughter. This is evident in the court process for the death of Dean Henderson-Smith. Even though the court in Oxford deemed the case gross negligence manslaughter in April 2013, Oxford Crown Court dropped the manslaughter charge

and found them (John Binning-from Great Park Farm and James Binning-from Bindings Farm), guilty of a health and safety crime in March 2014 (BBC, 2014a).

A remarkable aspect of the statistics is the number of accidental death verdicts (7 out of 73) and cases concluded without a penalty decision (37 out of 90). This is comparatively low compared to previous years.

One of the court decisions (a compensation order) was given in an incident in 2012-2013. After the death of Alex Haining, the jury concluded that the family should be paid £140,000 in compensation (Nellaney, 2015). Since the amount raised through fines goes to courts, local and central governments, and institutions, this decision was important. Additionally, the HSE issued a Crown censure for one case (the death of John Walmsley); I categorised this case and one crown censure decision as 'Investigated but no punishment for safety crimes'. Community and compensation sentences are presented in the number punished cases.

Figure 5.9 reveals that 'no information' and 'no further information on court process' cases occupied a considerable place within the policing of safety crime. According to statistical analysis derived from the data collection process, almost 30 per cent of whole cases (26 out of 90 cases) went unpunished. The graph shows that two common types of actions that led to deaths were vehicle crashes and contact with machinery.

*Table 5-10 Common causes of death in no information cases*

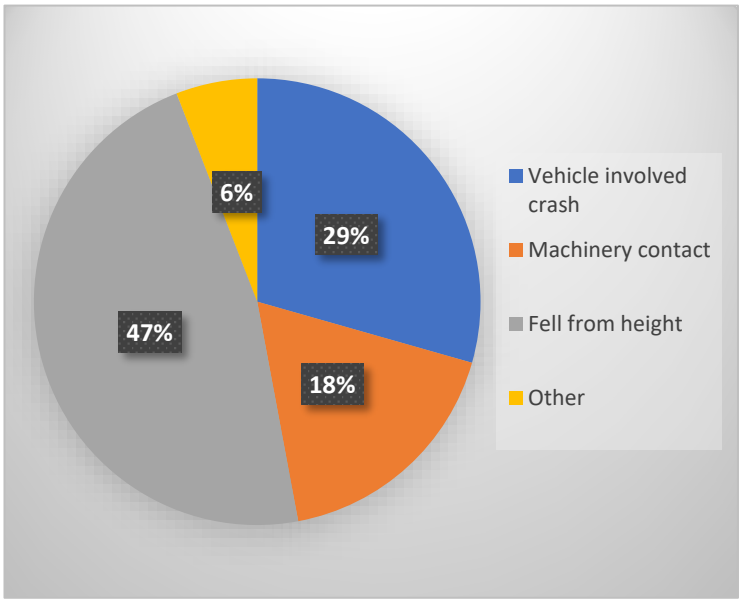


*Table 5-11 The values of fines (2012–2013)*


Table 5-11 shows that the majority of cases were concluded with fines above £100,000 in 2012-2013. Otherwise, the judge applied a low fine in a few cases (seven of them). One of these cases is worth highlighting here: Wolverhampton Court imposed a fine of a mere £1 in the case of the death of Mohammed Yasin (Health and Safety Executive, 2017a). The findings of this period show similar features to the previous period (2011-2012) considering the distribution of the imposed fines according to four categories shown in Tables 5.9 and 5.11. It seems that police agencies did not intend to impose severe fines for safety crimes, as can be observed from the few cases (five of them) that resulted in fines above £500,000.

Similar patterns emerged in the period 2012–2013, as most punished cases consisted of cases that involved convictions due to the violation of the HSW Act and regulations. Accordingly, three cases were prosecuted for gross negligence manslaughter, but agencies did make two guilty of gross negligence manslaughter decision.

## 5.7 The policing of safety crime from 2013 to 2014

One hundred and thirty-seven people died in the workplace in the period 2013–2014. I researched 79 cases out of 137, which included employees, people employed by other companies and trainees. I added two cases (the deaths of Gavin Brewer and Stuart Meads) in which HSE did not place their name on their record to the total number of researched cases. The prosecution process of these deaths resulted in corporate manslaughter conviction (BBC, 2016a).

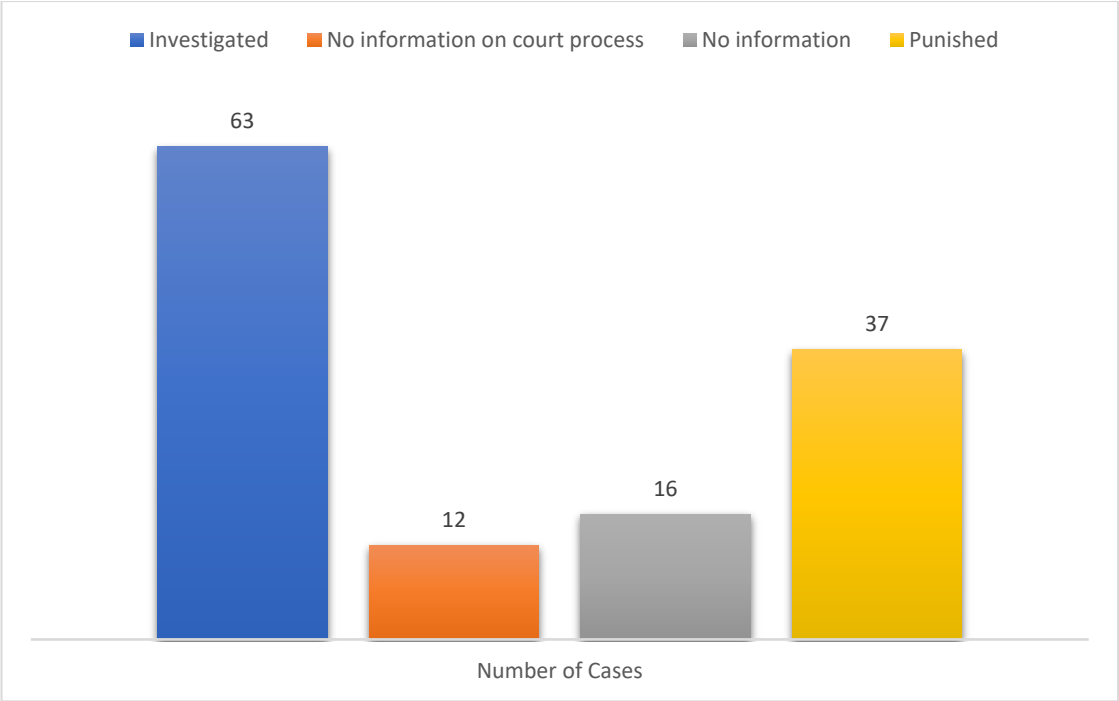
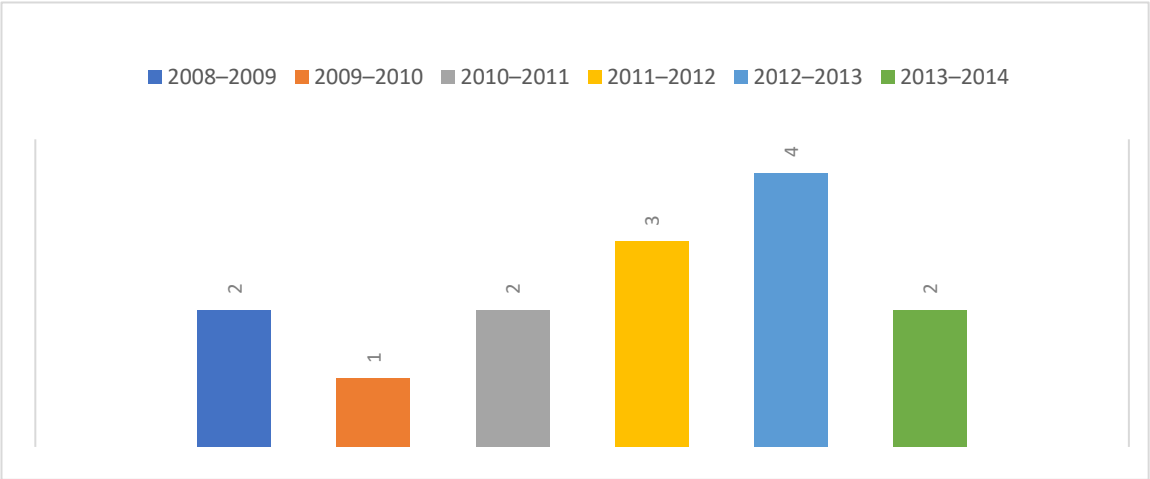



*Figure 5-11 The Results of Prosecutions of WRDs (2013–2014)*

The critical figure shown in ***Figure 5.11*** is that the number of cases that went unpunished (42 out of 79) is the lowest in seven years (see ***Figure 9.1***). This period also saw the lowest number of punished cases recorded in the eight years between 2008 and 2016. Two conditions caused this result to occur. The first condition is that the number of 'no information' and 'no further information on court process' cases is slightly higher in this period, and the second is the relatively low number of researched cases (79). However, a relatively high number of companies went to prison (nine) for manslaughter and health and safety violations.

*Table 5-12 Number of convicted cases under the CMCH Act*



Additionally, 5 out of 9 prison sentences was suspended, which is the lowest rate in six years. Table 5-12 shows that there was one conviction for corporate manslaughter recorded for two WRDs (Gavin Brewer and Stuart Meads) in the period 2013–2014.

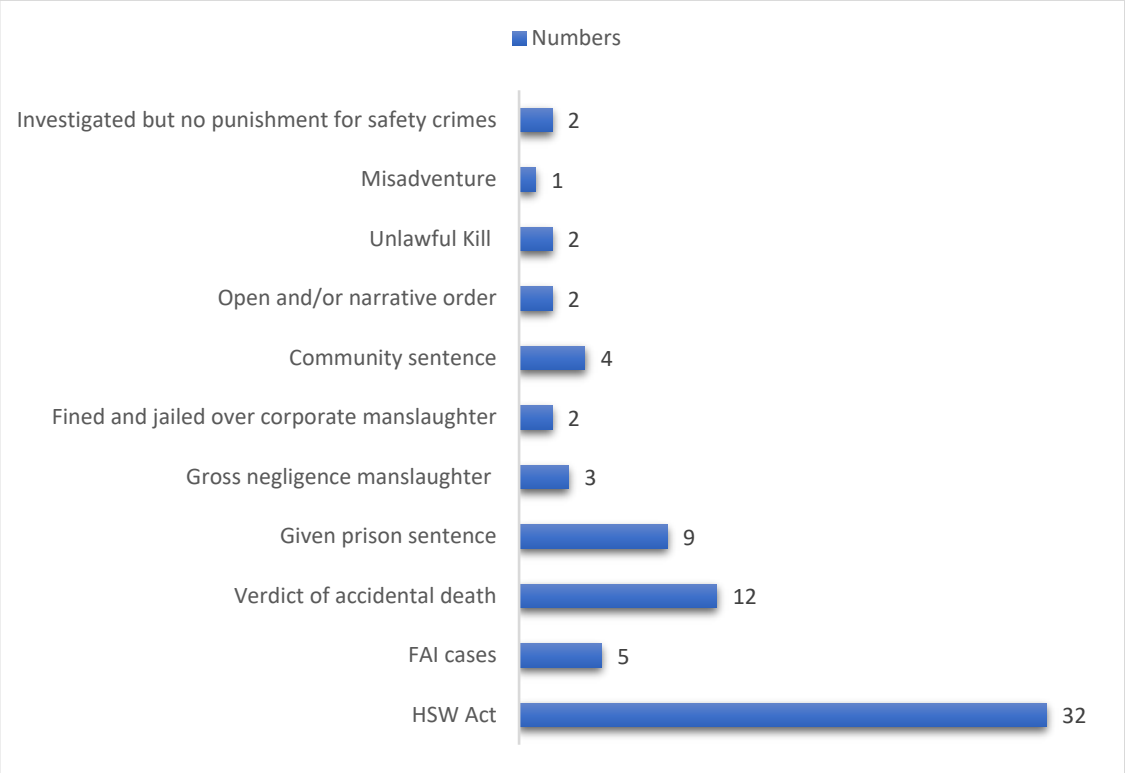



*Figure 5-12 The Response of the CJS to WRDs (2013–2014)*

The remarkable point in the statistics shown in ***Figure 5.12*** is the number of accidental death verdicts (12 out of 79). These verdicts refer the importance of the agencies' approach and evidence collection process. As an illustration, the prosecution process for the death of Richard Turner resulted in a verdict of accidental death and I could not find any information of guilty verdict, possibly because of insufficient evidence and a lack of witnesses. Richard Turner died on the 10th of January 2014, and the HSE went to the place of the accident six days later (Russell, 2014). According to a local media news report, the crime scene was changed, and some essential things, such as the crane, were not there. The HSE inspector did not detect any issues (Russell, 2014).

Agency's response to accidental deaths is sharing the coroner's concerns with relevant parties. I encountered this in one case (the death of Richard Laco) in the period 2013–2014. This can be evaluated as one of the criminal justice system's types of response to WRDs. Thus, one of these cases will be discussed in the vignettes chapter.

A relatively low number of cases remained unclear in this period. I could not access information about 16 out of 79 cases and could not reach the final verdict for 12 out of 79 cases. These cases

contribute to the perception that the criminal justice system fails to secure justice due to the low number of convicted corporate manslaughter cases. This can be observed through the 'no further information on court process' data in ***Figure 5.11.*** In these cases, agencies may have not sent the case to court because of challenges in collecting evidence and difficulties in finding a witness. Moreover, some deaths are perceived by agencies to be the result of a technical failure or a failure caused by workers. For instance, the sheriff articulated his view in the inquiry into the death of Ian John Black (see Chapter 8).

The other possible reasons that explain why I could not gain information in some cases are discussed in the sections analysing previous periods. In particular, finding evidence and witnesses in road and vehicle crash accidents may have been a challenge for agencies. Three out of the 16 cases that occurred between 2013 and 2014 were also a result of vehicle collisions. This is evident in the death of Anthony Saunders. Police made a public call to find witnesses, and it is high likely that they could not find witnesses or evidence, so the case was completed before it was sent to the court (BBC, 2013d).

The number of investigated cases indicates that the police and the HSE paid closer attention to workplace corporate offending than the CPS or the courts did.

*Table 5-13 The values of fines (2013–2014)*


There was a significant improvement in terms of applied sentencing for corporate offending. New sentencing guidelines covering corporate manslaughter, health and safety, and food safety offences were published in November 2015 (start date was 2016 February). These allowed the courts to impose higher fines and gave them greater authority over companies and individuals. Table 5-13 indicates that the majority of corporate criminals and health and safety criminals were fined between £100,000 and £500,000. Additionally, a remarkable number of companies had to pay huge fines. The statistical analysis shows that 50 per cent of the highest range was above

£1,000,000 in the period 2013–2014. The range of fines will be examined in the section titled 'Punishment' later in this chapter.

The analysis of the period 2013–2014 shows similar characteristics to previous years regarding the types of convicted cases, rate of uncompleted cases ('no information' and 'no further information on court process' cases), accidental death verdicts and cases prosecuted under healthy and safety regulations. Explanatory cases have been briefly examined to determine the characteristics of the most common verdicts. Statistical analysis shows crime agencies' responses to corporate offending, as agencies punished more than half of the investigated cases. However, police agencies were inclined to punish companies under health and safety laws rather than corporate criminal law. One of the categories is gross negligence manslaughter; in this period, three cases were prosecuted under common law. One of these cases will be examined in the vignettes chapter to understand the rationale behind this decision.

## 5.8 The policing of safety crime from 2014 to 2015

From April 2014 to April 2015, 142 people died in the workplace. I researched 82 cases out of the 142, which included employees and those employed by other means. A smaller number of cases were investigated from 2014 to 2015 compared to previous years (2013–2014).

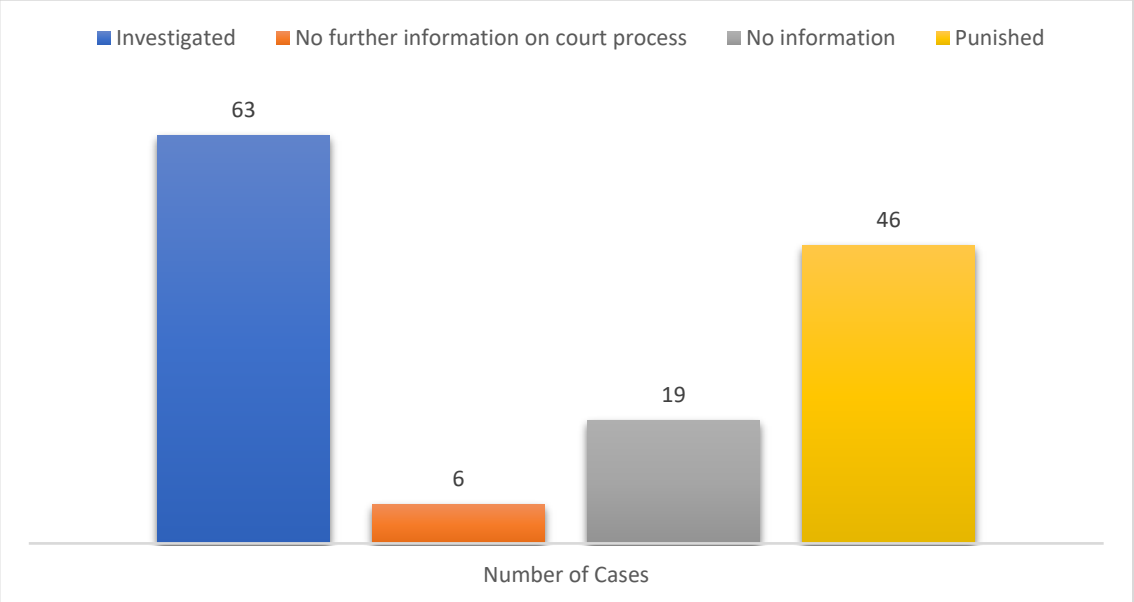


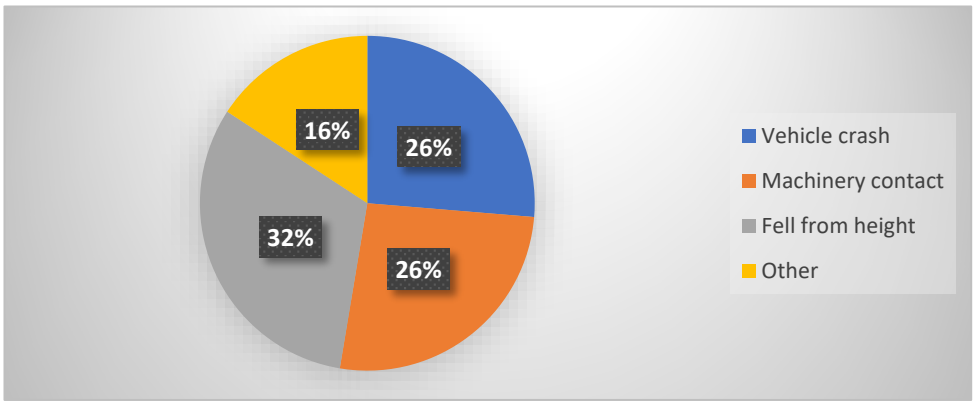

*Figure 5-13 IPP as a Result of WRDs (2014–2015)*

One notable figure in the statistics is that a relatively low number of cases (36 out of 82) went unpunished in 2014–2015. One case had not been concluded by June 2021; therefore, I included this in the 'no further information on court process' category.

In nine cases during the 2014–2015 period, the criminal justice system sent responsible actors to prison for gross negligence manslaughter, corporate manslaughter, health and safety violations and dangerous driving. This is one of the high number of convictions in the seven years between 2008 and 2015. However, in four cases, regarding the deaths of Benjamin Jon Edge, Safi Qais Khan, Robert Bird and Dale Pentney the courts suspended these prison sentences (see for some of them; BBC, 2017a; BBC, 2017b). Additionally, it can be seen from the data in ***Figures 5.14 and 5.19*** that one of the high numbers of corporate manslaughter sentences (in four cases) was given from 2008 to 2017. This indicates that the CPS and courts performed better at securing justice that year.

There were 16 'no information' cases from 2013 to 2014, which was a slight increase. A high number of cases remain unclear (19 cases). I could not access any information about 19 out of 82 cases. Furthermore, there was a significant decrease in the number of 'no further information on court process' cases (six out of 82). There were 12 from 2013 to 2014 and six from 2014 to 2015. The statistical analysis indicates a similar pattern to that observed in the previous periods: the main characteristics of the 'no information' cases primarily consist of accidents resulting from vehicle crashes, falls from a significant height and contact with machinery.

*Table 5-14 Common causes of death in no information cases*




I could not collect sufficient information regarding the court processes of several cases. The 'no further information on court process' figure for 2014 to 2015 indicates the smallest number of cases (six) compared to previous years.

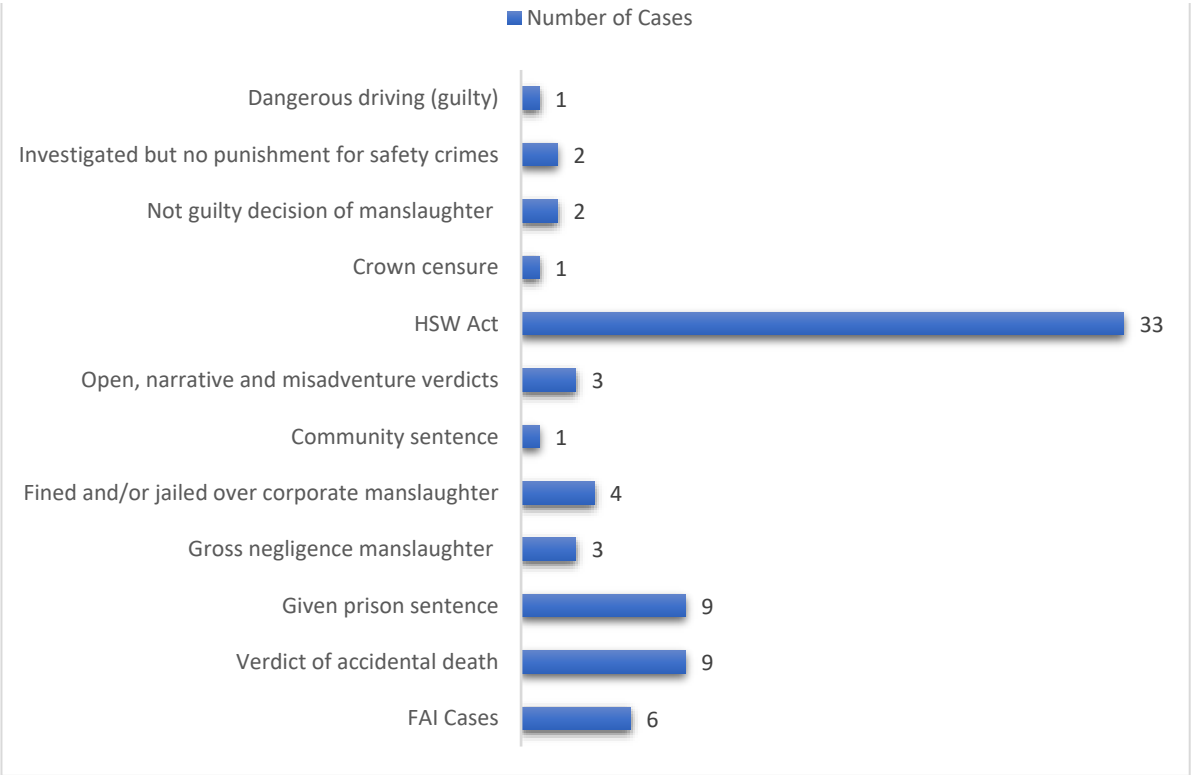



*Figure 5-14 The Response of the CJS to WRDs (2014–2015)*

***Figure 5.14*** is significant in several ways. First, most cases concluded with convictions under the HSW Act and the FAI(S) Act. This shows that the CMCH Act was not constantly applied in practice. Criminal justice agencies prosecuted a high number of WRDs; however, they categorised these offences as violations of regulations and health and safety acts rather than corporate manslaughter and gross negligence manslaughter.

Another noteworthy aspect of the statistics is the number of accidental death verdicts (9 out of 82). This number also reflects one narrative order open verdict and misadventure decision. These three types of decisions refer to the cases that may have resulted in charges. However, I could not find any information indicating different results either in official sources or mass/local media reports. Therefore, these results can be considered unpunished cases.

One of the illustrative figures is the sentences for verdicts of gross negligence manslaughter. Prison sentences were imposed in three gross negligence manslaughter cases rather than corporate manslaughter cases. The gross negligence manslaughter sentences are likely a factor in the low number of convictions in corporate manslaughter cases. If this punishment had been given for corporate manslaughter, the evaluation of corporate offences in terms of applied justice would be different. Some of these cases will be evaluated in the vignettes chapter.

One unusual aspect of the data in ***Figure 5.14*** is that the court returned a Crown censure verdict in one case. The court and the HSE preferred to impose a Crown censure instead of a more severe sentence, possibly because a governmental body (the Navy) was involved in this case.

In this period, the HSE records indicate the results of 39 per cent of all cases (30 cases). However, the statistical analysis indicates that the HSE does not include gross negligence manslaughter punishments and prison sentences in its records. The (possible) primary reason for this is that the records only reflect the results of health and safety acts and regulations violations, and corporate manslaughter verdicts.

*Table 5-15 The values of fines in 2014-2015*

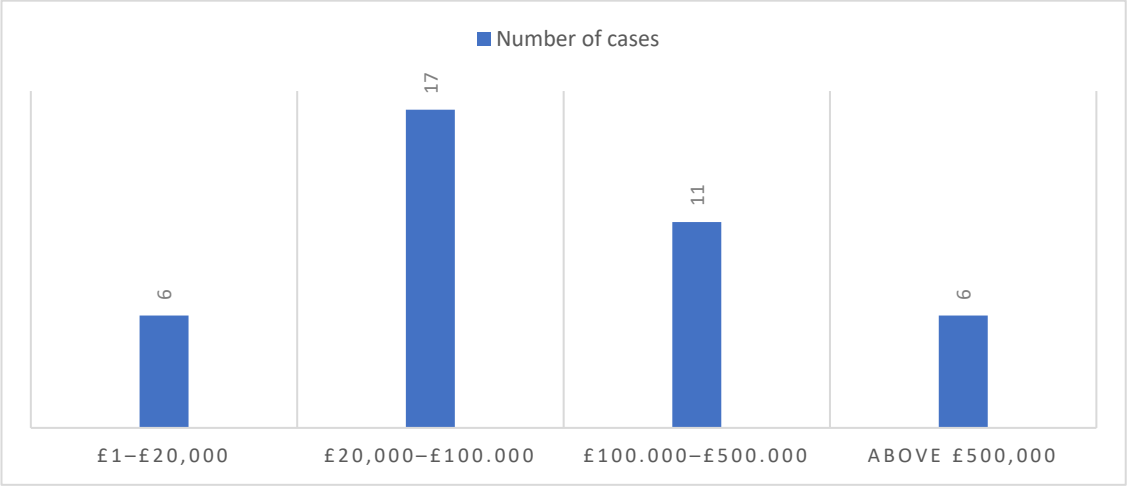



***Table 5-15*** indicates the number of cases the courts concluded, divided into four different penalty amounts. The table shows that the courts fined most companies and individuals within the range of £20,000–£100,000 between 2014 and 2015. Juries concluded a significant number of cases by imposing large fines. For instance, Nottingham Magistrates Court fined Explore Manufacturing Limited £1.3 million over the death of Richard Reddish under the Health and Safety at Work Act 1974 on the 16th of October 2017 (Health and Safety Executive, 2021a). An analysis of the primary cases that occurred from 2014 to 2015 has been briefly explained here, which helps to explain the reasons behind the low number of corporate manslaughter convictions and agencies' responses to work-related corporate offences. Even though the majority of cases were investigated, a smaller number of cases were punished.

Furthermore, only four of the investigated cases resulted in a verdict of corporate manslaughter. Agencies' most common response was to consider cases as health and safety offences, and the second most common type of response was an accidental death verdict. Lastly, 30 per cent of researched cases ('no information' and 'no further information on court process' cases) were

unsuccessful for particular reasons, such as difficulties in finding evidence and witnesses, the perception of agencies and the condition of the place of the accident.

## 5.9 The policing of safety crime from 2015 to 2016

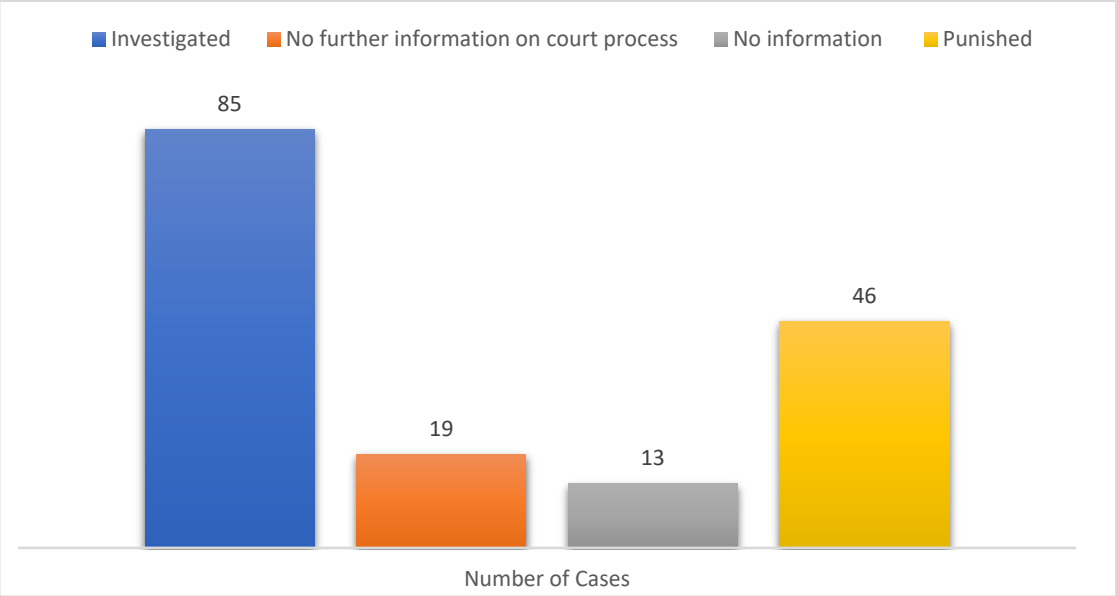



*Figure 5-15 IPP as a Result of WRDs (2015–2016)*

According to the HSE, 144 people died in the workplace from 2015 to 2016. I only focused on 98 cases. A higher number of cases was investigated from 2015 to 2016 than in previous years (2014–2015). In this section, cases that were not completed were placed in the 'no further information on court process' category. The details regarding the deaths of Kenneth Creswell, Christopher Huxtable and John Shaw were stated in the statistical analysis of the years 2015–2016.

One notable figure in the statistics is that a relatively high number of cases (52 out of 98) went unpunished in 2015–2016. On the one hand, the police and non-police agencies investigated the most WRDs (85 out of 98) to secure justice. This can be evaluated as a sign of high-level attention and satisfactory performance regarding the policing of corporate crime. On the other hand, relatively few investigated cases were punished in the courts (46 out of 85). The rate of punished cases is the same (46) as the previous period even though the number of researched cases increased in this period, compared to the period 2014–2015 (82 compared to 98). These findings suggest that police agencies (the court and CPS) made fewer contributions to securing justice than the police and the HSE.

The figure shows that there was a significant change in 'no information' cases compared to previous years (from 2014 to 2016; from 19 to 13). I was unable to collect adequate information related to these cases.

In 2015–2016, the police and non-police agencies did not perform as successfully as in the previous period (2014–2015) in terms of punishing responsible actors with prison sentences. This can be observed through the number of cases resulting in prison sentences (eight cases) including over corporate manslaughter, gross negligence manslaughter and other safety crimes which is presented in ***Figure 5.16*** in the categories 'Given prison sentence'. The total number of cases resulting in prison sentences was lower than in 2014–2015.

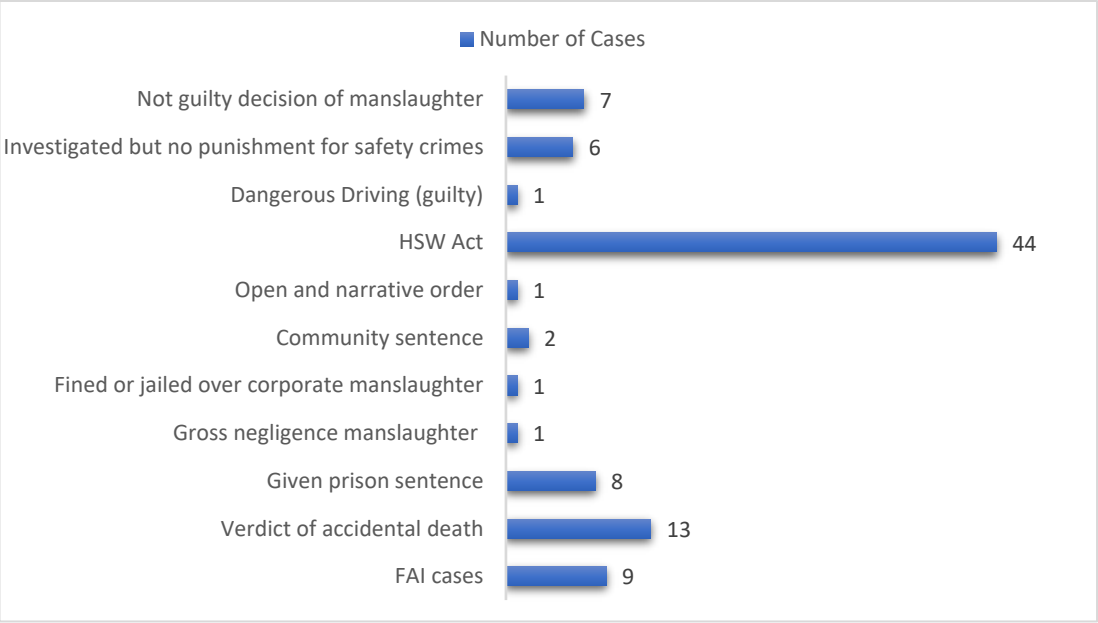



*Figure 5-16 The Response of the CJS to WRDs (2015–2016)*

The figure illustrates that fines were imposed for guilty verdicts over the health and safety act and regulations (43 out of 46). This figure presents findings to explain the low number of convictions in corporate manslaughter cases. Similarly, the prison sentence for gross negligence manslaughter is an insight to understand the low number of corporate manslaughter convictions. Prison sentences were imposed in one gross negligence manslaughter case rather than a corporate manslaughter case. Further, in one case (the case in which Derek Moore, Dorothy Bailey, Derek Barks and Jason Shingler died), the court gave a gross negligence manslaughter verdict in November 2019. However, in the aftermath of the next court hearing, which was held in April 2021, the Court of Appeal gave not guilty verdicts for gross negligence manslaughter (Ridler, 2021). These narratives show that police agencies deemed a low number of these cases to be corporate manslaughter.

These figures indicate that police and non-police agencies tend to apply the HSW Act and the FAI Act rather than the CMCH Act in WRDs. Further, the number of accidental death decisions is another aspect of the statistics that explains the importance of the coroner court's role in categorising wrongdoings. The courts concluded 13 cases as accidental deaths, including 'open and narrative order' cases, in 2015–2016.

Additionally, agencies closed the investigation process for fiver cases without sending them to the CPS or court. These cases are categorised as 'Investigated but no punishment for safety crimes' in ***Figure 5.16***. The reason is that the prosecution process was concluded without giving punishment.

In this period, the HSE published the results of approximately 30 per cent of researched cases online (31 out of 98 cases) (Health and Safety Executive, no date). Regardless of this period, HSE's records, which include convicted cases, may not include every convicted case, particularly if it happened in Northern Ireland. For instance, the death of Robert Wilson happened on 15 November 2010. JMW Farms Limited was punished for corporate manslaughter but the case is not in the HSE's records (Health and Safety Executive, no date). Additionally, some corporate manslaughter convictions may not be found in this record. For example, the Prince's Sporting Club, London was punished for the death of Mari-Simon Cronje in 2010, but this conviction for corporate manslaughter is missing from the HSE's records.

*Table 5-16 The values of fines (2015–2016)*

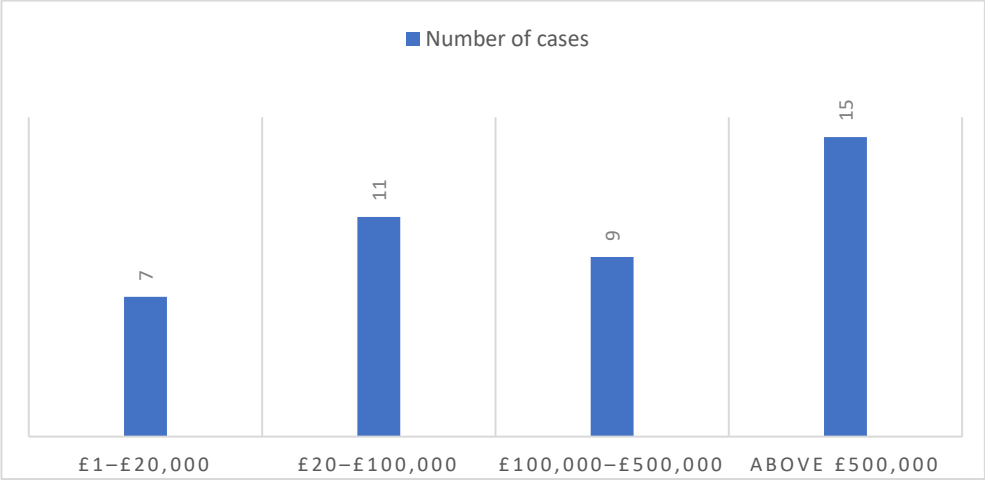
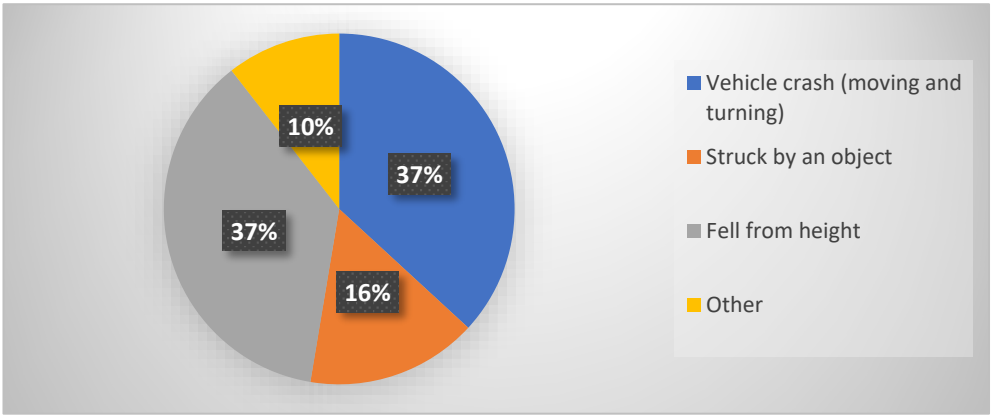



***Table 5-16*** indicates the number of cases in which the courts gave fines for convicted cases, and the penalties are divided into categories. The table indicates that judges fined most companies and individuals more than £500,000 between 2015 and 2016. In comparison with the previous period (six out of 40), the table shows that there was a sharp increase in the number of cases penalised above £500,000 (15 out of 42). Additionally, judges imposed relatively high fines

(£1,400,000 and over) for seven cases: the deaths of Leighton Jardine, David Beresford, Mark Sim, Peter O'Brian, Lyndon Perks, Wayne Thorpe and Jose Luis Santos Canal.

In previous sections, I indicated the main reasons for the deaths in 'no information' cases. Similar patterns can be observed in 2015–2016. ***Table 5-17*** shows that 'no information' cases primarily consisted of accidents resulting from vehicle crashes (moving and turning), falls from height and being struck by an object.

*Table 5-17 Common causes of deaths in no information cases*




The 'other' category represents information for two cases: hyperthermia and being trapped by something that has collapsed.

I observed similar reasons for many 'no further information on court process' cases. Another common characteristic of 'no further information on court process' cases is that some were prosecuted under FAI. I could not find the court results, even though there is a sheriff report. Prosecution under FAI is evident in the case of the death of William Black (Frazer, 2021). Another observation is that agencies could not continue the investigation process because of a lack of information, such as a lack of witnesses. For instance, in the Robert Vokes case, agencies publicly appealed for witnesses (Case, 2015; Johnstone, 2015). Some other similar cases have reflected the same characteristics. This is evident in the death of Matthew Harding. West Midlands Police questioned people to get information about the accident (BBC, 2015a), but I could not obtain further information on the court or police prosecution. This is likely a common feature of these kinds of cases.

In summary, the response of police and non-police agencies to WRDs can be categorised into five main groups: 1) corporate manslaughter cases (six out of 98), 2) 'no information' and 'no further information on court process' cases (uncompleted prosecution process cases; 32 out of 98), 3) accidental death verdicts (13 out of 98), 4) cases under health and safety regulations (49 out of 98) and 5) gross negligence manslaughter (three out of 98). Each category presents narratives to

understand the reasons behind the decisions about whether these cases were corporate manslaughter. The statistical analysis helped us to determine the most critical categories that reflect agencies' responses to WRDs. Some of these cases were analysed in the section titled 'The Role of Agencies and the Implementation of Justice'. Further, I chose cases and vignettes from these five groups to analyse in Chapters 6, 7 and 8.

## 5.10 The role of institutions and the implementation of justice

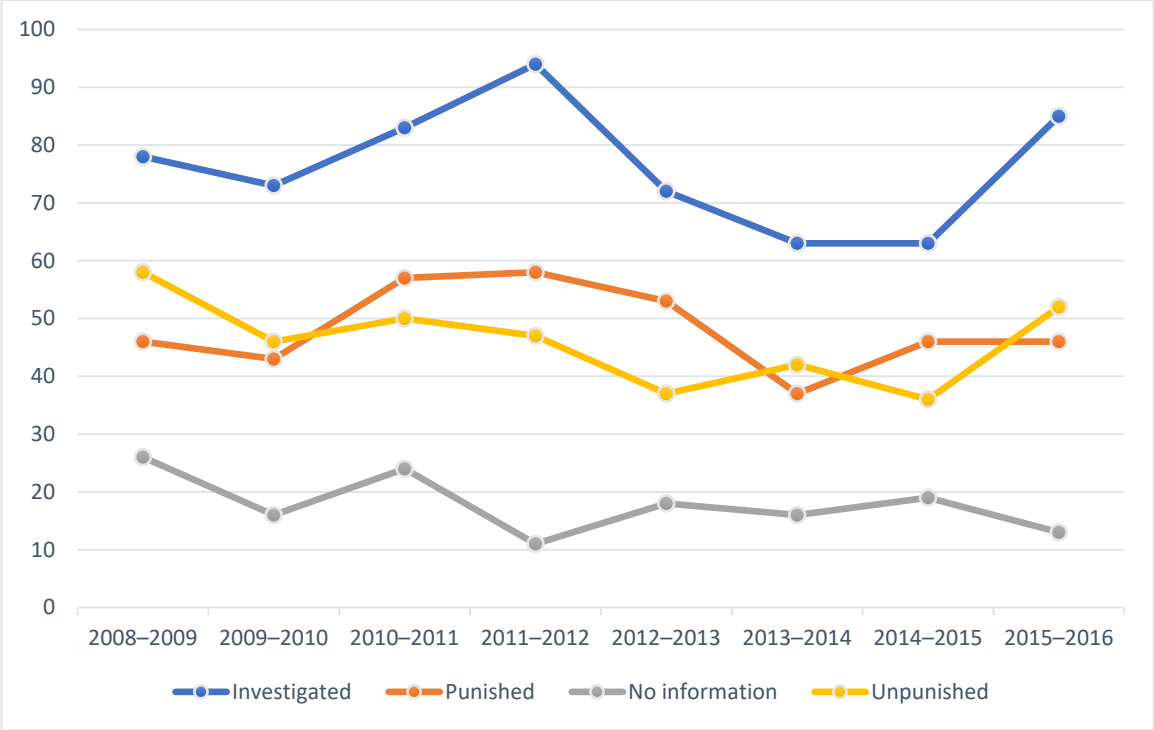



*Figure 5-17 IPP as Results of WRDs (2008–2016)*

The remarkable point to note in ***Figure 5.17*** is the high number of investigated cases and the comparatively low number of punished cases. In the four periods (2010-2011, 2011-2012, 2012-2013 and 2014-2015), there were more punished than unpunished cases. The CPS and courts' attention to corporate offending can be observed from the number of convicted corporate manslaughter cases. In contrast, the HSE and police's attention can be observed from the number of investigated and punished cases. ***Figure 5.17*** shows that the HSE and police paid more attention to WRDs than the CPS and the courts.

However, it is likely that the police agencies did not take a crucial role in considering WRDs as a crime. This is evident in ***Figure 5.19,*** as only 19 cases of 754 WRDs were categorised as corporate manslaughter. There were also five more convictions, which are not presented in the figures because they were not included in the HSE's statistics. In total, 24 out of 759 WRDs (five cases are presented in the ***Figure 5.19***) were categorised as corporate manslaughter. The role of the CPS

and courts is more influential than the role of the HSE or police in terms of considering a case to be corporate manslaughter.

The only significant decrease in the number of punished cases after 2008 was observed in the period 2013–2014. The reasons for this decrease were discussed above (see Section 5.7).

The criminal justice system deemed most cases to be violations of regulation rather than corporate manslaughter. One of these cases that exemplifies a problematic investigation and punishment process occurred between 2011 and 2012. In this case, Chevron (a big company) was fined £5 million for a health and safety crime at Swansea Crown Court (BBC, 2019a). This compelling case raises a crucial question: why was this case not prosecuted under the CMCH Act instead of the HSW Act? The ostensible reason is that the CPS did not find strong evidence to charge the companies (B&A Contracts Ltd and Chevron) with corporate manslaughter (BBC, 2015b). However, the court decided that serious wrongdoing led to workers' deaths and charged two companies for health and safety failings. The four workers (Robert Broome, Andrew Jenkins, Dennis Riley and Julie Jones) were killed because safety measures were not taken. One of the hindsight of this case concerning the prosecution process is that the Crown Prosecution Service may have foregrounded the immediate causal factors over the damage caused by the companies' organisational behaviour or policies for more benefit. The other implication is that agencies play a crucial role in successfully settling disputes and failing to secure justice.

The courts did not always give prison sentences under the CMCH Act. For instance, the responsible parties were mostly found guilty of health-and-safety regulations, and most of these verdicts were suspended, with seven out of nine prison sentences suspended in the 2011-2012 period.

### 5.10.1 Investigaton and prosecution processes

Several cases were prosecuted and punished under various laws and regulations, including the HSW Act 1974, the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976, the Health and Safety Work Regulations 1999, the Health and Safety Work Regulations 1989 and the Corporate Manslaughter Act 2007.

In most cases examined, companies broke the law and regulations, but almost half of these cases were not sent to the courts. This is evident in ***Figure 5.20.*** The prosecution processes for some typical cases ('no information' cases and accidental death verdicts) provide insights that underpin this situation.

The court and CPS may play a more crucial role than the police and HSE in terms of the legal system's failure since the courts deliver verdicts based on the evidence collected, the HSE's reports and police advice reports. This is evident in many unpunished and accidental death verdict cases. For instance, Tony Ockwell died while working on a roof on the 27th of July 2012. In this case, the HSE investigated the case with the police. Even though the police sent the case to the CPS, the CPS decided that there was not enough evidence to open a criminal investigation for corporate manslaughter (Daily Echo, 2015). However, Bournemouth Crown court punished the company for violating health and safety regulations by fining them £26,600. The same scenario can be observed in other WRDs, such as the case of Callum Osborne, which is discussed below.

A respondent articulated agencies' roles in determining a case of corporate manslaughter by highlighting the primary role of the police:

> The decision in terms of who investigate[s] whether or not to investigate a company for corporate manslaughter rests with the police. So, it's not an HSE decision, although we may have the conversation with the police to suggest if we think that there might be a potential for those kinds of gross failings, that would give rise to a possible corporate manslaughter possibility for the bar for corporate manslaughter are the sort of minimum standard to be met for the CPS to consider it. We would raise that with the police, but the decision is not for us. If the police decide in their experience that they don't agree that meets the bar, what we will do with HSE is continue our investigation (14/05/2021). [As a result,] the decision about whether or not to investigate a company for corporate manslaughter rests with the police and not HSE. The evidence required to prove corporate manslaughter is only occasionally found, whereas health and safety offences are relatively common (17/06/2021).

However, some, such as Pearce and Tombs (1998) and Tombs and Whyte (2007), have criticised the HSE's performance on corporate offending by stating that the unwillingness of the HSE plays a role in the low number of investigated cases. These authors explain that the high number of non-investigated cases results from the problematic perception of safety crime – which is seen as accidental or not a serious crime – and from the relationship between policy and the economy.

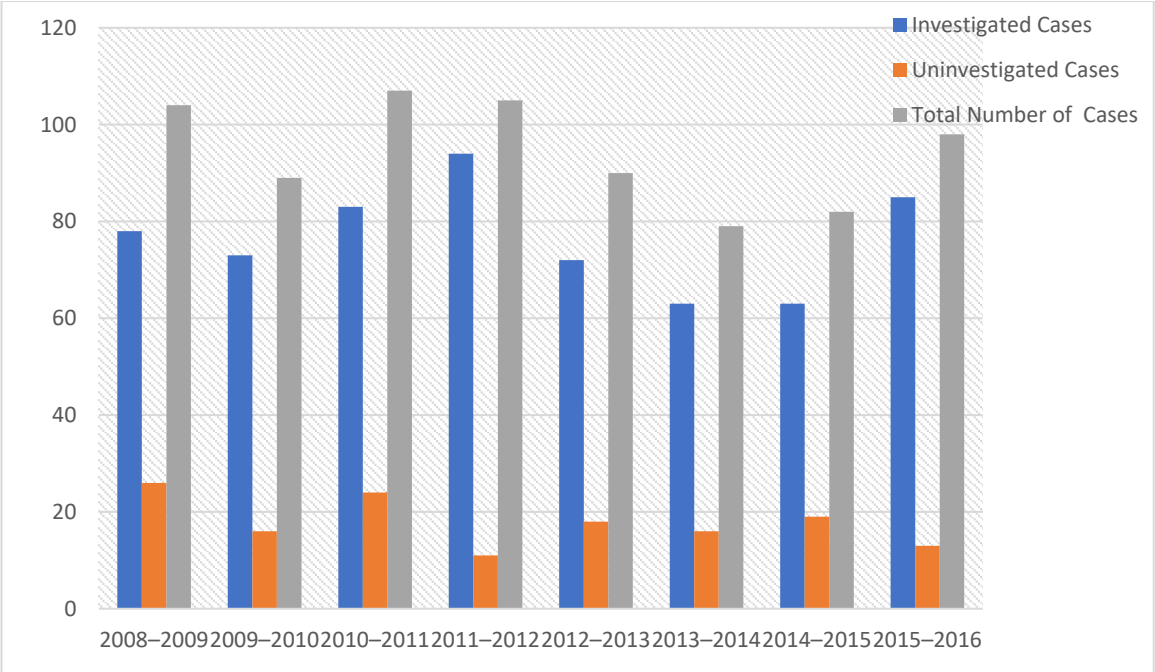



*Figure 5-18 The Results of the Investigation Process for WRDs (2008–2016)*

The figure above presents the number of investigated cases from 2008 to 2016. These investigated cases include those that the police and HSE investigated before they were sent to police agencies. The majority of deaths were investigated by the police or the HSE. The table indicates that the HSE and police took a more critical role in securing justice than the CPS. This can be seen in the case of George Falder, in which the court deemed Falder's death to be accidental (BBC, 2015c). However, after three years, the HSE led to open a criminal investigation and collected evidence of the company's negligence. It was only then that the court punished the company. Even though the penalty was relatively lenient (a fine of £150,000), the HSE had contributed to the securing of justice (Applebey, 2015). A participant in the case stated that the main actor that ensures the punishment of incidents under the CMCH Act is the HSE.

HSE P1 explained in detail the prosecution process:

> HSE's involvement with a fatal workplace incident starts when we are notified, usually by the police who are called to attend the incident scene, or the employer under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. Initially, the investigation is carried out jointly with the police, who have 'primacy' in (lead) the investigation until they are satisfied that there is no evidence of an offence (including corporate manslaughter) other than a health and safety offence. HSE may attend the scene to ensure that there are no ongoing risks (which we have the power to stop), and work alongside the police to gather documentary and physical evidence and witness statements. In practice, most workplace fatality investigations are handed to HSE soon after the incident.
>
> HSE only investigates those fatalities which occur in locations/undertakings for which we are the enforcing authority. The Health and Safety (Enforcing Authority) Regulations 1998 set out those

> premises which are enforced by HSE and those which are enforced by local authorities. (In local authority-enforced premises, the investigation is carried out by the local authority, but potential legal breaches are the same, and the investigative processes and procedures are similar.)
>
> HSE continues to investigate until we are confident that any ongoing risks have been controlled and that we have followed all reasonable lines of enquiry to establish whether there have been breaches of health-and-safety law. Once all reasonable lines of enquiry have been followed, we conclude our investigation and decide on appropriate enforcement action. HSE's investigation procedure provides our criteria for curtailing or closing an investigation (06/01/2021).

The HSE is one of the best trained of the crime-related agencies. This was evident from the fieldwork. HSE P1 indicated:

> The investigation of workplace fatalities follows similar principles and methods to other workplace investigations. In the HSE, investigations are conducted and overseen by HM Inspectors of Health and Safety, who have received extensive training in health-and-safety law, workplace/industrial processes and the law relating to the collection and admissibility of evidence (06/01/2021).

Analysing these records provides essential insights into the prosecution and investigation processes. For example, the police can send a case to the HSE rather than the CPS, as they did in the case of Pawal Pagos who was killed in 2010 (BBC, 2010b).

An interesting finding is that the majority of workplace corporate crimes were admitted by companies in the court process, in contrast to how rarely corporate manslaughter was admitted. This concurs with Levi and Lord's statement about the court process for corporate crime:

> Some corporations and individuals may admit to regulatory offences to reduce hassle and time, whereas they would strongly defend and sometimes succeed against criminal charges because of their imputation of dishonesty and the collateral consequences of conviction for the right to bid for government contracts (Levi and Lord, 2017, p.725).

Another important finding is that agencies could not take a role in the prosecution process for some cases (those that were concluded with a verdict of accidental death or non-prosecution cases) because agencies could not find evidence or witnesses. These conditions obfuscate the assessment of whether these cases should be defined as crimes.

Some accidental death decisions were converted into conviction decisions. Specific illustrative vignettes will be evaluated under HSW convictions in the vignettes chapter. However, I have provided a brief overview of a few examples under this current section. As mentioned earlier, the HSE plays a more critical role in securing justice than the CPS or the courts. Two cases support this argument, and in both cases, the jury initially gave a verdict of accidental death, but the HSE continued the prosecution, and the companies were subsequently punished. The first case is that of Gethin Kirwan, who was killed in April 2013. The jury returned a verdict of accidental death in

June 2014 at Ruthin Coroner's Court (North Wales Live, 2014); however, Wrexham Magistrates' Court later sentenced Thomas Price (the director of the company Kirwan worked for) in February 2015. A similar situation occurred in the case of Scott Millington. In this case, the jury returned a verdict of accidental death in October 2014 at Lincoln Cathedral Centre (Riley, 2014); however, Lincoln Crown Court fined Lincoln Proteins Limited with £66,000 in August 2016 (Health and Safety Executive, 2016a).

Some WRDs occur because of minor injuries, and courts deem these cases to be accidental deaths. This is undoubtedly true in the case of Stuart Jones, a prison officer who died because he injured his knee while trying to stop a prisoner escaping at Stafford Prison (Express and Star, 2013). After evaluating the HSE's report, the jury returned a decision of accidental death, which indicated that the required procedures were successfully followed.

### 5.10.2 Punishment

***Figure 5.17*** indicates that crime-related agencies help to secure justice. The agencies concluded with penalties for around 51 per cent of cases concerning workers' deaths in the period 2008–2016. This presents a relatively optimistic picture in terms of justice being secured. However, a few cases concluded with a prison sentence or a verdict of corporate manslaughter. This is outlined in ***Figure 5.19.***

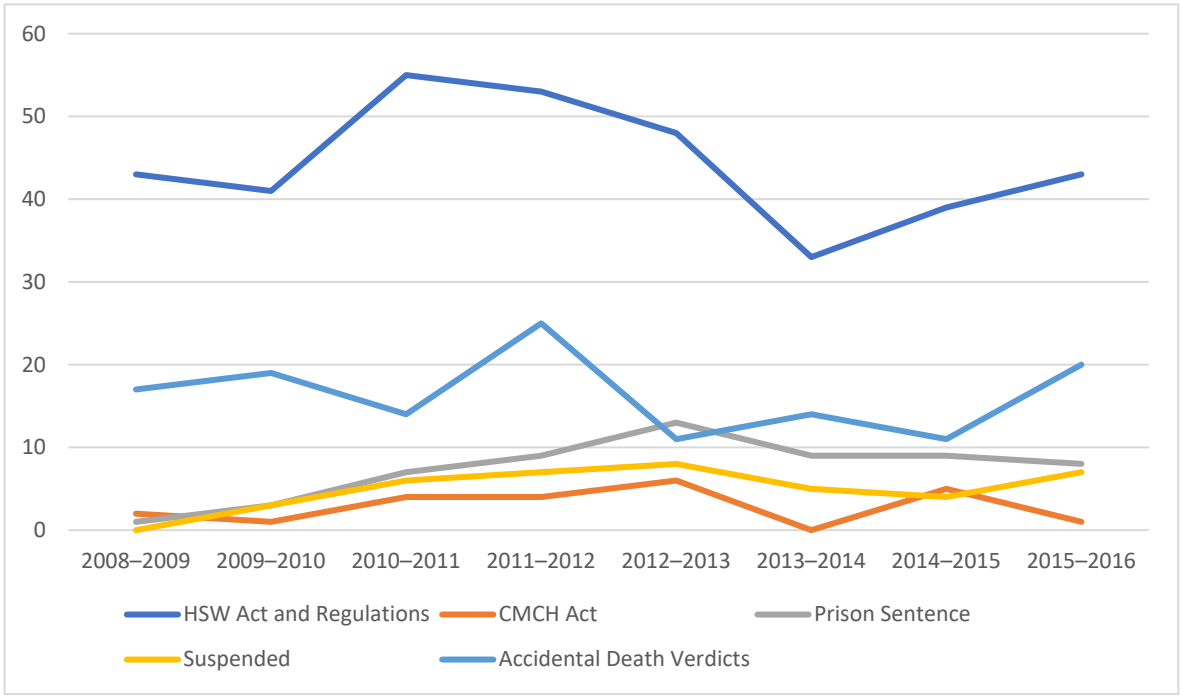



*Figure 5-19 The Response of the CJS to WRDs (2008–2016)*

As ***Figure 5.19*** shows, there has been a fluctuation in the number of cases resulting in prison sentences. The highest number of prison sentences given was 13, which occurred in the period

2012–2013. In total judges gave 59 prison sentences in the eight-year period, only 21 which were not suspended. As mentioned in the Section 3.4, corporate criminals have not often gone to the prison compared to other types of criminals (Galvin, 2020; Campbell, 2019; Reiman, 2007, Box 1983).

The police and non-police agencies applied different versions of punishment apart from prison sentence and fines: (i) compensation, (ii) publicity, (iii) community sentence, Crown censure, and prohibition notice. The rarest type is publicity order. One of them is given in the death of Jason Pennington. The order in this case was published on 3 February 2015 in a newspaper stipulating '[a] publicity order to advertise what happened on the company website for a set period of time and to take out a half-page spread in the local newspaper; and pay costs of £31,504.77' (Applebey, 2015). This is one of the rare instances that shows the seriousness of corporate offending to society.

One of the narratives is that the amount fined is determined according to the company's size. Two critical results are worth mentioning here. First, every company can be punished and prosecuted, regardless of size. Even though high numbers of punished companies are small, the courts have punished huge companies by imposing high fines. For instance, a jury charged Total UK Limited £1.4 million for breaking health and safety rules (BBC, 2015d), whereas another company was only fined £3,000 under the HSW Act (BBC, 2012b). One company (Recycle Paper UK) was only fined £1 for a worker's death, and this punishment can be seen as interesting because the company went into liquidation (Rannard, 2017). Second, courts pay attention to whether a company will continue to work or not, and courts consider companies' contributions to the economy when they are imposing penalties for criminal activities. For instance, the big size steel company Tata Steel was fined £450,000 at Sheffield Crown Court for causing a worker's death. The court could have imposed a higher fine on the company, but the judge considered the sector's economic profit: 'Tata – which was called Corus until 2007 – could have been fined up to £800,000, but this was reviewed in light of the UK steel industry's "financial realities"' (BBC, 2018a). This case presents an important insight into the factors and conditions that affect whether a case is considered corporate manslaughter. Even though Tata had a bad history of implementing health and safety measures, it did not face a corporate manslaughter charge in this case (BBC, 2018a). It is difficult to say that having a poor safety record is not sufficient grounds to prove a company's illegal activities are corporate manslaughter.

Similar patterns can be observed in the Callum Osborne[5] case, during which the CPS considered existing evidence insufficient and, therefore, did not open a criminal investigation (BBC, 2014b). However, the court handed down a 12-month suspended sentence and a £75,000 fine (Parry, 2015). The judge stated that 'he'd taken into account the effect prison would have on Cooper (site boss)'s children and his new company' (Parry, 2015). This shows that company size may only be a factor when determining the level of penalty imposed. In other words, a company's size may not be a factor in determining whether a company should be punished.

A member of the HSE (P1) mentioned how the size of a company is a factor in prosecution and punishment processes:

> Because I wonder there's in a way, we could almost say that it perhaps discriminates against smaller companies not intentionally, but you might say it's actually a lot easier to find, in the case of a small company where the director or senior manager is on the ground, because it's theoretically easier so that he knew exactly what was going on. (…) It potentially I mean, I don't actually know what the data shows in that, you know, if you were to look, past been convicted of corporate manslaughter, are they big companies or smaller companies? Possibly not possibly this is this is not a real issue. But it just theoretically, if you need to have that smoking gun, that points to somebody in senior position directly, it when you have a larger company, that they're much more likely to be quite far removed, the majority of health and safety offences happen with failings in some part of the system. So local poor practice that grows up, you know, or a certain practice in maybe a construction company, something happens on a site that does not fit the normal way that the company that the policies and procedures that are in place, and that is a breach, often of health and safety law, it probably is not going to be a breach of the corporate manslaughter Act, because the company did not do anything (17/06/2021).

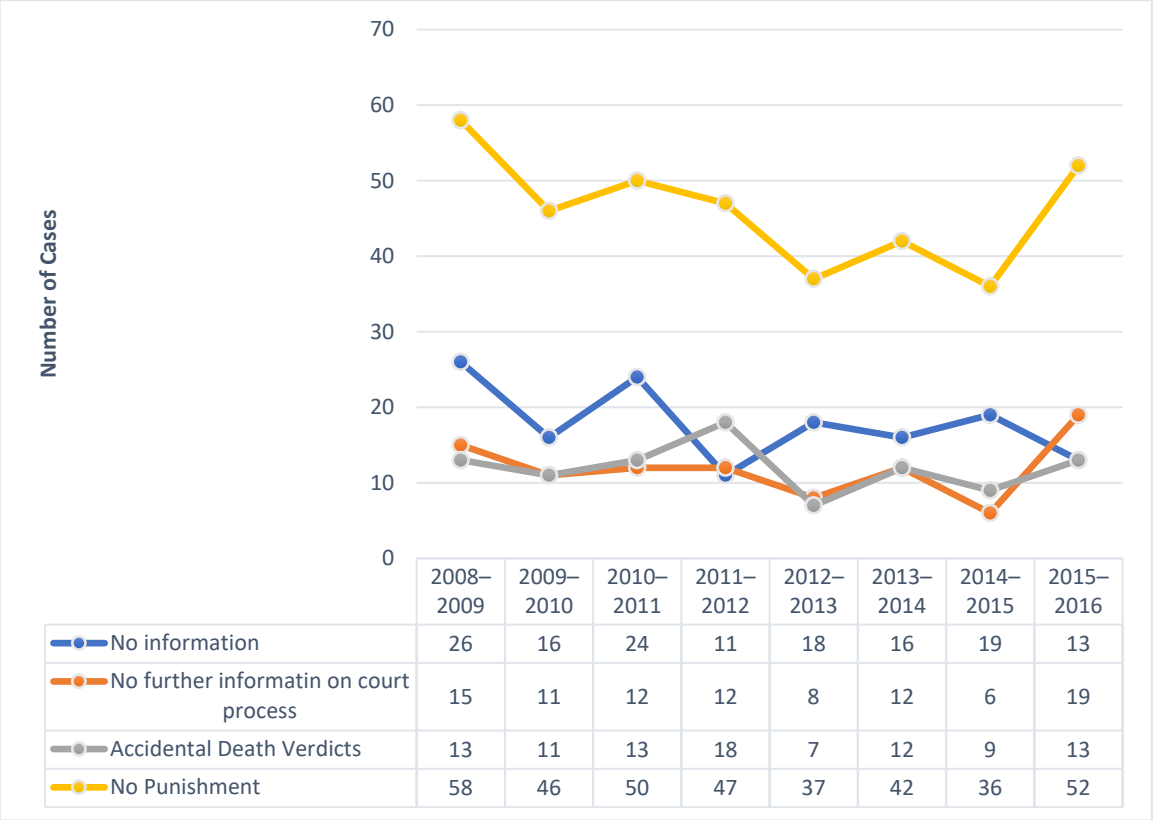
This participant's statement shows that it is difficult to say that the size of a company is a crucial factor when it comes to punishing it. However, it seems that the prosecution process for small companies is more straightforward than for big companies.

## 5.11 Comparison of 8 years period (2008-2016): The response of agencies to WRDs

Under this section, some categories presented in this chapter are compared throughout nine years (2008-2016) considering the investigation and punishment process of WRDs. The total

[5] In this case, the jury concluded that the worker's death was an accidental death in October 2014, but after one year, probably because the HSE decided to bring further action, the court punished the owner of the company and the company.

number of cases that resulted in corporate manslaughter, gross negligence manslaughter and violation of health and safety regulations are presented.



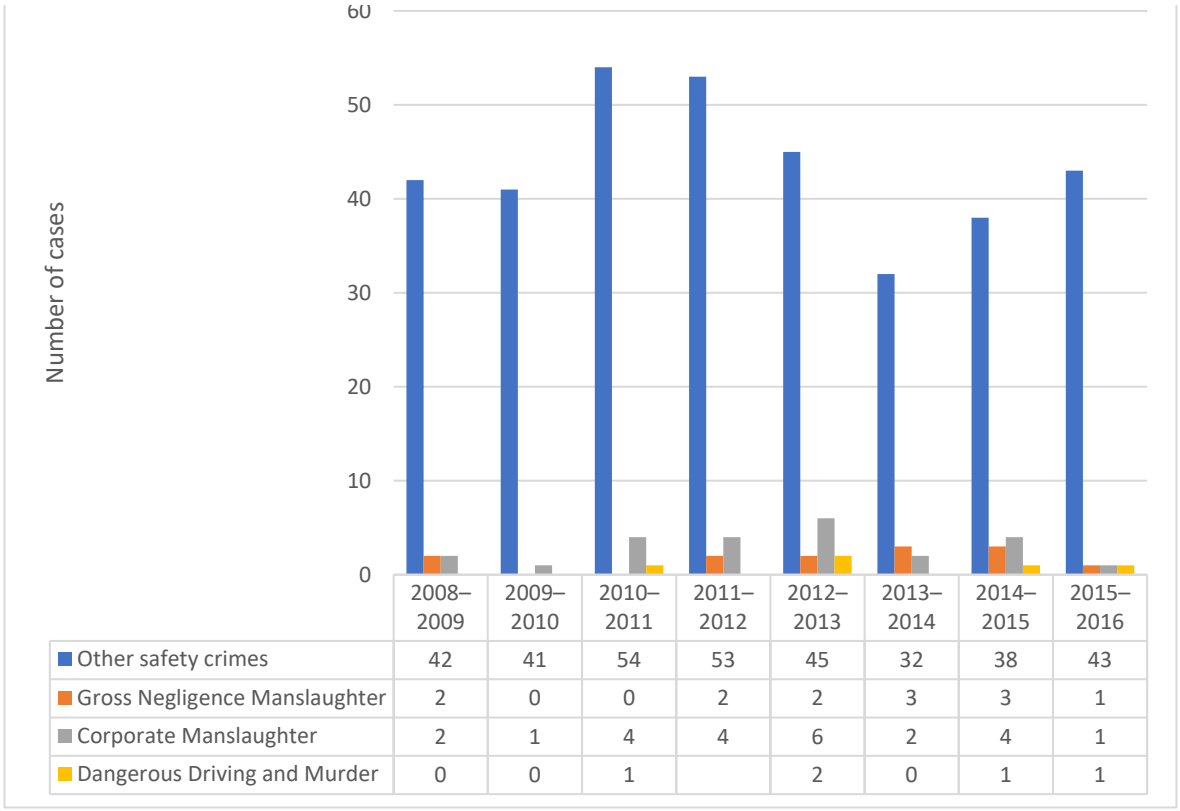

| | 2008–2009 | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 | 2013–2014 | 2014–2015 | 2015–2016 |
|---|---|---|---|---|---|---|---|---|
| No information | 26 | 16 | 24 | 11 | 18 | 16 | 19 | 13 |
| No further informatin on court process | 15 | 11 | 12 | 12 | 8 | 12 | 6 | 19 |
| Accidental Death Verdicts | 13 | 11 | 13 | 18 | 7 | 12 | 9 | 13 |
| No Punishment | 58 | 46 | 50 | 47 | 37 | 42 | 36 | 52 |

*Figure 5-20 The result of safety crime policing (2008-2016)*

***Figure 5.20*** indicates that a huge number of cases (368 out of 754) went unpunished in the eight years period which almost equals to 49 percent of all cases. There had been fluctuations in all categories between 2008 and 2016. This means that there had been no remarkable improvement in securing justice in nine years. The number of unpunished cases peaked (almost 56 per cent of all cases) in 2008-2009 while a low point (41 per cent of all cases) in 2012-2013.

No information figure shows that 143 cases were out of the attention of police and non-police agencies. In comparison, 95 cases went possibly unpunished even though these cases were investigated by police and non-police agencies.

There had also been a significant number of cases (accidental death verdicts) reflecting the inquest process of WRDs in eight years period that 96 cases were evaluated by coroner or coroner courts. I have only found the inquest result of these cases instead of a criminal court or any punishment information. It had been observed that in only a few this kind of case resulted in convicted, which are categorised as punished cases. Therefore, it seems highly possible that these cases went unpunished due to several reasons, such as the agencies' policy and perception of safety crimes.




| | 2008–2009 | 2009–2010 | 2010–2011 | 2011–2012 | 2012–2013 | 2013–2014 | 2014–2015 | 2015–2016 |
|---|---|---|---|---|---|---|---|---|
| Other safety crimes | 42 | 41 | 54 | 53 | 45 | 32 | 38 | 43 |
| Gross Negligence Manslaughter | 2 | 0 | 0 | 2 | 2 | 3 | 3 | 1 |
| Corporate Manslaughter | 2 | 1 | 4 | 4 | 6 | 2 | 4 | 1 |
| Dangerous Driving and Murder | 0 | 0 | 1 | | 2 | 0 | 1 | 1 |

*Figure 5-21 The Comparison of Punished Cases (2008-2016)*

The police agencies evaluated merely 3.16 percent of all cases (24 out of 759) as corporate manslaughter. Some cases (5) not placed in the record of HSE even though they are presented in this figure. Additionally, the agencies gave only 13 gross negligence manslaughter (GNM) verdicts over 754 cases. It indicates that the police agencies not even considered 5 per cent of all work-related corporate offending as manslaughter in eight years period.

The Crown Prosecution Service shared (via Freedom of Information in April 2023) information of guilty and not guilty decision of corporate manslaughter and gross negligence manslaughter and charges brought under health and safety legislation according to the date of the case (not due to verdict's date)[6]. There had been 19 corporate manslaughter, 12 gross negligence manslaughter and two manslaughter (it was not known whether they were gross negligence manslaughter or corporate manslaughter) verdicts for the cases that happened between April 2008 and April 2016. The CPS's data presents similar results to this thesis. However, the CPS did not disclose some types of information for the cases; thus, the reliability of the CPS's data is questionable.

[6] I presented a prosecution result for each case while CPS shared prosecution result for multiple cases. For instance, CPS's data reflect 'one not guilty corporate manslaughter decision' for MNS Mining case, while in this thesis, it is counted as 'four not guilty decision' for the MNS Mining case because four workers died in this case.

The majority of punished cases (349 out of 754) resulted in violations of health and safety regulations. It is difficult to say there is a gradual increase in the number of punished cases between 2008 and 2016.

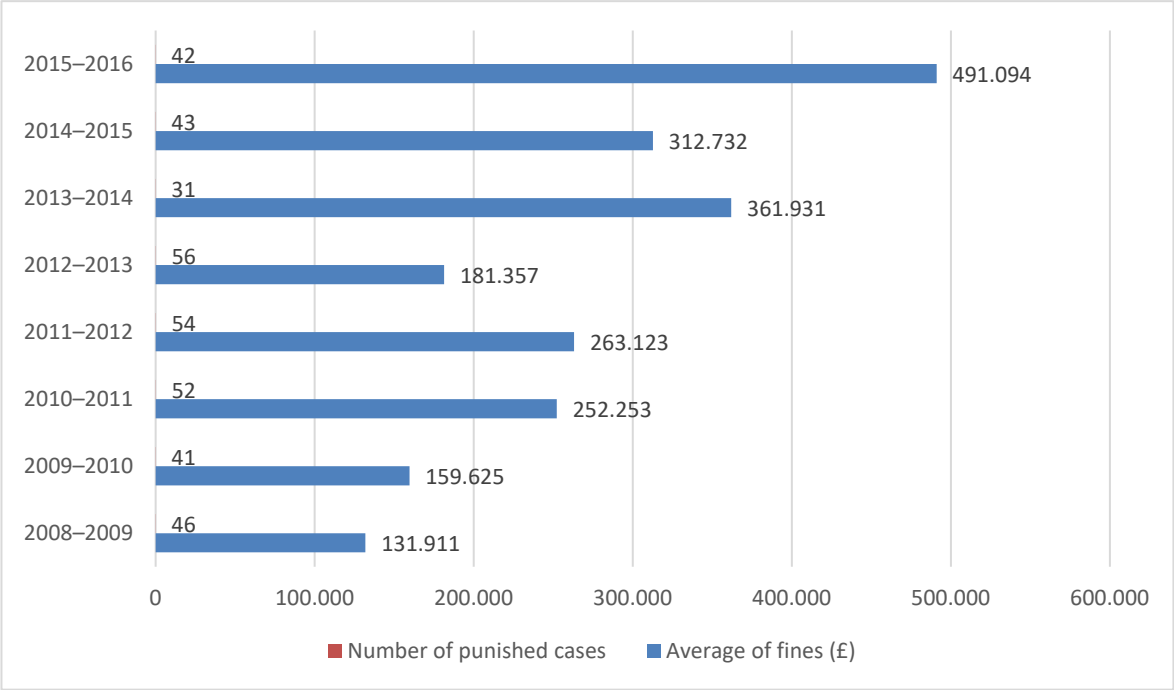



*Figure* 5-22 ***The Annual Average of Fines and Punished Cases (2008-2016)***

***Figure 5.22*** shows police agencies gave relatively very lenient fines to corporations for wrongdoings that led to deaths in two years period (2008-2009 and 2009-2010) compared to other periods. ***Figure 5.22*** indicates a remarkable increase in the average of fines after the 2008-2009 and 2009-2010 periods. There have been several reasons to explain this increasing trend; (i) the different number of punished cases in the periods, (ii) the number of cases concluded after 2016 (new sentencing guideline came into force; see the section 5.7), and (iii) the number of cases resulted in a high fine (particularly in corporate manslaughter cases). For instance, in 2013-2014, the average of fines was relatively high as the number of punished cases with fines (31) was low, while the cases involving fines of £500,000 and above (8 cases) were relatively high. Four WRDs' prosecution process resulted in fines of £1.000,000 and above in 2013-2014. The increasing trend after 2012-2013 can be explained by the effect of new sentencing guidelines (2016 Sentence Guidelines). Many cases (which happened after the 2012-2013 period) resulted in 2016 and following years.

## 5.12 Conclusion

First, this chapter looked at the investigation of and punishment for WRDs to elucidate how UK government policy and legislation against WRDs have been implemented from 2008 to 2016.

Second, I focused on the role of police and non-police agencies in terms of considering a case to be a crime in 759 cases. UK government policy and legislation concerning safety crime have been implemented in various and complicated ways. One evidence is that different laws and regulations are applied for the similar type of wrongful behaviour. This may be evaluated as a sign of inconsistent legislation policy with regard to corporate manslaughter.

The findings derived from the statistical and documentary analysis of WRD cases are categorised into five main groups: 1) Cases prosecuted under corporate manslaughter law; 2) 'No information' and 'no further information on court processes' cases; 3) Cases investigated under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (inquest process and verdicts) regarding the result of the IPP. These categories can be considered as a summary of criminal justice system's response to safety crimes. Each group's pattern gained through statistical and document analysis of an eight-year periods (2008-2016) provides different narratives to answer research questions. These narratives will be discussed with other chapters' findings in Chapter 9.

The analysis indicates that accidental death verdicts occupy a significant place (almost 16 per cent of all cases) in treating work-related corporate offending.

This chapter indicates that police agencies have evaluated a few cases as violations of criminal law and given prison sentence as gross negligence manslaughter. Although agencies evaluated a few cases as manslaughter, they were not considered as corporate manslaughter. The analysis of this category may help to research questions; thus, one of the vignettes focuses on this type of case.

***Figures 5.17, 5.18, 5.19 5.20, 5.21 and 5.22*** present a broad picture of the government's legislation and policy against work-related corporate offending from 2008 to 2016. Only 31 of 754 (36 out of 759) cases were prosecuted during this time under the CMCH Act. Importantly, less than 31 of these cases (only 19 out of 386) were punished under the CMCH Act. The characteristics of these cases (convicted and non-convicted) and situation (a low number of corporate manslaughter cases) will be analysed through two case studies (see Chapters 6 and 7).

The statistical analysis found that police agencies punished almost 46 per cent of WRDs under the health and safety act. Importantly, 90 per cent of punished cases were treated as violations of health and safety laws instead of criminal or corporate criminal law.

The analysis of 'no information' cases shows that almost 19 per cent of WRDs were not investigated, which means 19 per cent of WRDs cannot be defined officially as crimes (apart from accidental death decisions). 12.4 per cent of all cases consists of 'No further information on court process' cases. Some vignettes have been chosen from 'no information' cases to understand the narratives for uncompleted prosecution processes and unpunished cases (see chapter 8).

This finding illustrates that government policy and legislation concerning WRDs undermine the expectation of justice, considering the low number of convictions and a high number of unpunished cases. The analysis of these findings extends beyond articulating agencies' responses to and their role in corporate offending. In addition, the analysis enables us to determine the rationales and criteria for choosing cases and vignettes. The rationales are as follows: (i) each category refers to different narratives. An in-depth exploration of these narratives and patterns of work-related corporate offending will help answer the research questions, and (ii) examining these cases is necessary to understand the influencing factors and the role of agencies in the police agencies' consideration of whether a case is corporate manslaughter.

The criteria are as follows:

1) There are five main types of results. Vignettes must provide insights that help us understand each type of prosecution result. Hence, they should be chosen from these four main types.
2) Vignettes should be explanatory and reflect the patterns of the four different result types.
3) They must have taken place between 2008 and 2016, and their court process must be complete.

One of the successful cases under the CMCH Act illustrates the importance of agencies' roles in the prosecution process. In that case (the death of Lindsay Easton), a member of the HSE (Thompson, 2015) stated:

> This was a complex investigation involving a high level of collaboration between HSE and Lancashire Police especially in relation to the forensic examination of the crane's braking systems. This joint working with Lancashire Police contributed to bringing this case to a successful conclusion.

Statistical analysis shows that the HSE and the police paid close attention to cases from 2008 to 2017. Thus, the entire criminal justice system may not be blamed for not functioning correctly, and the fight against safety offences may not be said to have been entirely unsuccessful. However, securing justice for WRDs is problematic because corporate manslaughter sanctions have been applied reluctantly. As such, the statistical analysis indicates that several factors, such as the evidence collection process, attention from agencies and the structure of the CMCH Act, all contribute to creating this picture, which can be conceptualised by considering illustrative cases. The next chapter will analyse one of these cases (The Death of Nikolai Valkov).

# Chapter 6 The Death of Nikolai Valkov

## 6.1 Introduction

The picture gained from Chapter 5 brings us to another problem, which cannot be conceptualised by looking at whether WRDs are punished seriously by criminal justice agencies. Therefore, one convicted corporate manslaughter case has been chosen to understand why some cases were considered corporate manslaughter and others were not. This chapter is an analysis one of the first of two case studies.

A broad analysis of two cases (Nikolai Valkov and MNS Mining) helped to determine the characteristics of these cases. Understanding the role of police and non-police agencies and the application of the Corporate Manslaughter and Corporate Homicide (CMCH) Act could aid in analysing corporate offending in the United Kingdom (UK). These roles and factors can be scrutinised using multiple case studies. One such study is the death of Nikolai Valkov, which represents a successful application of the CMCH Act. Crucially, unlike most cases related to corporate offending, this case resulted in a verdict involving a prison sentence, in which the role of Police and non-police organisations, such as the court and the Health and Safety Executive (HSE), played a pivotal role. Several factors make this case a successful example of the CMCH Act in practice. An analysis of these factors, and the case itself, is divided into three main sections: (i) the background, (ii) the court investigation and (iii) the role of the relevant police (police, court and CPS) and non-agencies (HSE and local authorities).

The Nikolai Valkov case has never been studied in detail by conducting interviews and documentary analysis of court hearings in the literature (due to my best knowledge). The analysis of this case contributes to corporate crime literature by describing the role of agencies and by identifying the factors which shaped the verdict. Moreover, the case study enables the researchers to indicate the conditions that describe a wrongful action as a corporate manslaughter by police agencies. The first aim of this chapter is to understand the factors that led to the last decision by seeking court discussion, interviews and news reports. The second aim is to show how police and non-police agencies approached the case based on collected data. As part of these aims, I paid attention to disagreements among actors on evidence and particularly punishment.

The qualitative methodology and document analysis help us to analyse research data in this case (see further detail in Chapter 4). The research sources consisted of in-depth interviews, mass and

local media news, official sources (Companies House, the HSE), court hearing transcriptions and legislations.

## 6.2 The background

The case's background provides information about and analyses the history connected to the incident, the moment of the accident and events directly afterwards, and the characteristics of the company, such as its size, experience in the relevant industry and health and safety record.

### 6.2.1 The history of events connected to the accident

This case began in February 2011 with the necessity of a roof repairment at the Ozdil House (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). The HSE and local authorities were involved in the case from 2011 to 2015. Unsafe working conditions were observed in 2011, followed by a telephone conversation in July. Communications between Ozdil Investments Ltd. and the health and safety authorities continued over telephone and email during the next few years. After the 18th of February 2015, Koseoglu Metal Works became involved in these communications regarding the preparation of the safety conditions (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017).

### 6.2.2 The accident and events that took place afterwards

Nikolai Valkov was hired by Koseoglu Metal Works Ltd. He was fatally injured while repairing the roof of Ozdil Investments Ltd.'s warehouse in Harlow. He reportedly fell six metres through a 'fragile skylight concealed by dirt and lichen roof light at unit 4 of Ozdil House, one of six industrial buildings which were located on the site' (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 4). He sustained a fracture to the skull and died within hours in the Princess Alexandra Hospital on the 13th of April 2015.

Before these hours, Mr Valkov went to the area located between units 2 and 3. He attempted to remove the roof sections, and Mr Kose helped him until almost noon. One witness stated that:

> As there was no welding work to be done that day, all the other Koseoglu staff were carrying out roofing work, which included installing guttering. He [the witness] said the angle grinder was used to cut overhanging asbestos from the roof, and that was the standard practice for the site. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 10)

Police and non-police agencies perceived the reason leading to the fatality as being a lack of safety precautions, rather than toppling from the tall height (Regina v Ozdil Investments Ltd. and

Koseoglu Metal Works Ltd., 2017). Contrary to the court discussion, this process was explained by P1(01/13/21) in the following way:

> This friend [Nikolai Valkov] went to the roof and did business by himself, not wearing his seat belt, not wearing his helmet. Of course, we were supplying them, but this person did on his own, go to another region from the region he is in, even though I did not say it. He did not know there, and business, and then the roof is broken, and he fell.

The CPS placed a similar statement in the court. However, the CPS stated that it was not very clear considering the evidence and the result of the accident (see Section 6.3.1 for further information).

It is reportedly recorded that Ozgur Ozdil, and another person were working in the area and 'the cage on the forklift containing Mr Kose is lowered quickly from the roof, and before it touches the ground Mr Kose can be seen jumping from the cage, for he, Mr Akpulat and Ozgur Ozdil, all run out of the view of the camera towards units 1 to 5' (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 11). One of the workers at the court pointed out that, although Mr Valkov did not put on an identifiable jacket, the witness saw him with a 'fluorescent jacket' before going out from the workplace (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 8). Bektas Ozdil controlled the forklift, and he moved away from the entrance. He then continued to work, unloading a heavy goods vehicle (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017).

Studying information from the participants may provide a different approach when reviewing published documents. For example, P1 gave important information about the beginning of the prosecution and court process:

> When our accident happened, the police came. The place was surrounded where we do business, and they circled. I do not remember exactly, but there was an inspection period of between 15 and 20 days to understand what and how it happened. The police took me to the police station and took my statement. It took three hours or so and was not officially recorded. **After the discussion was over, the police said to me 'okay you can go'. I was just leaving the police station when we received the information that the worker had died. As he was not dead when he went to the hospital, they took me back in and said to me that because 'the man died, we will take your statement again' and got my recorded statement** [author's emphasis]. It took a long time, around 4–5 hours. It was in the morning, 4 or 5 am, when I left the police station.
>
> They let me out after that; however, the process continued. Initially, a lawyer was given to me by the government. After a while, I hired a lawyer myself, and they [courts, police, HSE and defendant's lawyer] communicated amongst themselves. (13/01/21)

These statements – which were not discussed in court – show that the police and non-police agencies, such as the HSE, gave much more importance to the case after learning that the accident had resulted in the death of an employee.

Two critical points are made: almost every aspect of the accident was recorded and confirmed by witnesses and cameras. The second point is that unsafe working conditions were highlighted, in detail, by the Crown prosecution in the court. It shows that the evidence collection process was quite successful in that details of the accident were recorded, and these records were presented in court by the Crown prosecution.

### 6.2.3 The characteristics of the companies

Two small companies were responsible for the accident leading to the death of Nikolai Valkov. The first, Koseoglu Metalworks Ltd., was founded by Kadir Kose on the 20th of December 2011, and dissolved on the 29th of January 2019, according to the official records of Companies House (Companies House, 2019). The second, Ozdil Investments Ltd., was launched on the 9th of July 2009, and is still running, as of July 2020 (Companies House, 2020a). The company had five directors, four of whom resigned between the 10th of July and the 22nd of May 2017. Currently, only one active director of the company, Bektas Ozdil, remains. In this case, it is evident that Ozdil Investments hired Koseoglu for the roofing work. There was one more company – Ozdil UK Ltd – that has some of the same directors (Serhat Ozdil, Firat Ozdil and Bektas Ozdil) as Ozdil Investments. The importance of Ozdil UK is related to the directors and where the accident took place. Ozdil Investments was also the landlord of Ozdil UK Ltd (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 19). There was a warehouse behind the accident site that belonged to Ozdil UK Ltd. Additionally, a forklift was found in the warehouse that had been used by one of the directors (Bektas Ozdil) and had been involved in the accident.

As discussed earlier in Chapter 3, a company's size might be a factor affecting the potential of prosecution. To date, all companies charged under the CMCH Act have been small or medium in size (Tombs, 2018), which could be due to the relative ease of finding 'controlling mind' and connecting the wrongful action of company in such companies compared to larger ones (Hébert, Bittle and Tombs, 2019; Tombs, 2018). Indeed, it is widely accepted that the senior management test can be applied more easily in cases involving smaller companies (Hébert, Bittle and Tombs, 2019; Tombs, 2018). The defining factor in this case was the evidence gathered in punishing the companies. The court considered Ozgur and Serhat Ozdil to be responsible (as managers of the company) for the wrongdoing, even though it was highlighted that their authority in the company only takes effect when other brothers are abroad (Regina v Ozdil Investments Ltd. and Koseoglu

Metal Works Ltd., 2017). Further, this issue (of finding controlling and responsible people) was a relatively critical issue considering the court transcription. , The collected evidence enabled the controlling minds to be easily identified within company (see The collected evidence, The CPS and The punishment). As it was highlighted in the literature review, the possible reason is that the companies are small.

## 6.3 Court investigation

The court investigation provides insight into the evidence and its collection process, the agencies' prosecution process and the Judge's approach to the case. In addition to this, the description of crime and punishment regarding the applied Act is analysed. The court investigation identifies factors to indicate whether the chain of events can be considered a crime. This analysis is broken up into three themes: (1) collected evidence, (2) judge's approach, and (3) punishment.

An appropriate first step is to recite the whole story through the eyes of the participant. P1 detailed the court and punishment process by saying that:

> We went to court from time to time. As far as I remember, we went to a low-level court (probably Magistrates court) two or three times. Once or twice, we went to the high court (Crown Court). They let me go again. By all means, by the way, of course, the lawyer gathered evidence, and the Police collected evidence, and this took two years. This process concluded within two years, we were at the court, and they arrested us at the court. They gave 12 months to the main owner. They gave 10 months to [one of us] and gave me eight months prison sentence. **We spent four months of the given eight months in prison** [author's emphasis]. I was sent to prison for four months; he served time in prison for five months with approval, [another one] served six months of the given 12 months in prison. Here, after the prison sentence was over, they gave an eye arrest. Sorry I said wrong, I spent two months out of four months, [another one] spent two and a half months, and another one was sent for three months. (13/01/2021)

### 6.3.1 The collected evidence

Police and non-police agencies collected various evidence, such as a lack of protection equipment, failure of safety conditions and ignorance of necessary precautions, by means of photographic evidence, documents and witness statements.

It was reported in court that the emergency service members did not observe any safety protection (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). In addition, the Crown revealed more proof of unsafe conditions via testimony from witnesses and inspectors:

> the forklift and the cage were examined by a specialist inspector and found both to be totally unsuitable for the use that they were being put to. It is apparent from the photographs of the

> scene, taken on the day of the incident, that a significant amount of work had been completed by the time Mr Valkov fell. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 9)

The following evidence was given by witnesses:

> [...] they saw between two and four men walking around on the roof without any safety equipment on. They saw males doing jobs on the roof, such as sweeping dirt into tubs, drilling wooden batons onto the roof, or just generally walking around [in late February or early March 2015]. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 9)

Recordings of a similar issue were also shared in court (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017).

The head of court scrutinised whether or not there were failures in the health and safety conditions. The Judge asked about this issue to the defendants, and the response is worth stating here:

> **[Defence]:** I accept there was material which showed that he had harnesses. Not enough, that's the first, obvious, point. But, it wasn't always the case, with respect, that the evidence showed that it was just him and not others. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 35)

Despite the efforts of the defence to justify the working conditions, the lack of protection was demonstrated by witnesses and photographic evidence. The CPS critically approached the statements of the company director and defence team by indicating that:

> […] Now, in relation to events on the 13th of April, he said that towards lunchtime he and Mr Valkov went to unit 4, where he gave him his helmet and his harness and told him to clean the top of the inside wall. He maintained during his interview that Mr Valkov had not been on the roof and that he must have fallen from a ladder within the unit. When CCTV was shown to him, he conceded that he and Mehmed had worked on the roof with no safety measures in place. But, as far as Mr Valkov was concerned, he was certainly anxious at that stage to deny any – even that Mr Valkov had been on the roof (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p.13).

Valkov's wife reported the company's failure to provide safe working conditions. Her statement aided in convicting the companies in court. The Judge mentioned that 'Mr Valkov said to his wife before he left for work that fateful morning, was that he was going to collect his wages and leave the job because the safety was not good, and the work was not good. But his wife said he had not – he did not have a choice to leave, he couldn't afford to leave; he needed to work to support and feed his family' (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 40).

A critical issue detailed in court was the ignorance of necessary precautions. The court hearing shows that communications between the companies, the HSE and local authorities continued for almost one year. However, it was not enough to alter behaviours regarding safe working conditions. It was evident in court that:

> Mr Kalou informed the Ozdils that they would need a method statement, and that he would need to re-notify the HSE. He also told them that he had not met the contractor, and he would 'not do anything unless I was happy with what they were doing'. Mr Rayeef said that he heard nothing further from any of the parties following that meeting, even though he had been expecting to hear from Mr Kadir Kose about when the work would start. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 9).

Statistics around the investigation and prosecution processes related to workplace deaths indicate that applied laws may change, depending on how well companies pay attention to the warning. The CMCH Act covers these failings (see further info, CMCH Act 2007).

### 6.3.2 The Judge's approach

The court discussion is a critical source for understanding Police and non-police agencies' approaches to crime. The statements of the Judge provide clues to how seriously the case was taken and the points that the Judge paid closest attention to.

The statements reflect both the Crown Prosecution Service (CPS) and Judge's approaches to the case regarding actors not taking responsibility to prevent accidents.

> The prosecution say that these failings were conscious decisions taken by Ozdil Investments Ltd. to act contrary to the advice and unambiguous warnings of those who were seeking to establish a safe system of work, and to ensure the safety of those working on the roof of Ozdil House. They gambled with workers' safety and having been specific – they gambled with workers' safety having been specifically warned of the potentially fatal results of such a gamble (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 15).

As discussed in Chapter 3.6, safety crimes are not seen as serious crimes (Hébert, Bittle and Tombs, 2019; Levi and Lord, 2017; Friedrichs, 2015: Almond and Colover, 2012). However, in this case, agencies and, in particular, the Judge perceived the wrongdoing as a severe crime and gave prison sentences, even though the defence emphasised the damage to family ties and aggrievements that would occur (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). It was articulated in court that:

> Your counsel stand in front of me asking me not to send you to prison because of your families, and how much they will miss you, and how difficult life will be for the short time you are in custody. Mr Valkov's family lost him for good that day and have lost a very great deal; their houses, their lives, their finances, and they have suffered and he will never come back. Yet, your counsel come in front of me and tell me how difficult life is going to be for you. You had the choices. You each ran your own companies, and you could not be bothered to follow the rules and do the job properly so that people like Mr Valkov, who had no choice, had to do what you told them to do, and you were content (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 41).

The Judge did not suspend the prison sentence, contrary to many cases. The Judge's explanation can help to conceptualise the reason in court:

> As far as sentence is concerned, I say at the outset the I am very firmly of the view that this case crosses the custody threshold, and as far as all of you are concerned, I do intend to send

> you to prison and I do not intend to suspend any of your sentences; I make that clear. The reason I do that is because of what I have said, you had the choices and you chose to send Mr Valkov up to that roof, knowing full well what was expected of you. You were willing to take that chance, not with your lives or your family's lives, but with his life, and that must be marked. That is the reason why, when my attention is drawn to the sentencing guidelines and I am asked to consider whether or not I should suspend any such sentences, I make it clear that I do not suspend them on that basis (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 42).

### 6.3.3 The punishment

The final verdict of the Valkov case reflects a common feature of these kinds of cases. Kadir Kose, the owner of Koseoglu Metalworks, accepted responsibility for the accident that led to Nikolai Valkov's death when all the evidence and reports were discussed in court on the 27th of September 2016 (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). Statistics indicate that the owners or directors of companies usually admit their guilt in court. However, Ozdil Ltd. did not accept the charges. Nonetheless, the jury returned guilty verdicts to both companies after inspecting the reports and evidence.

Following a four-week trial, Ozdil Ltd. was found guilty of corporate manslaughter and of breaching Section 3 of the Health and Safety at Work Act of 1974. Additionally, two of the company's directors (brothers Firat and Ozgur Ozdil) were convicted under Section 37 of the Health and Safety at Work Act of 1974. The company was fined £500,000 for the corporate manslaughter offence and £160,000 for the health and safety offence. The company was also ordered to pay £53,115.34 in costs on the 19th of May 2017. Firat and Ozgur Ozdil were sentenced to 12 and 10-month prison sentences, respectively, and were disqualified from working as company directors for 10 years on the 19th of May 2017. The company was charged with a relatively low fine due to the sentencing guidelines regarding punishing micro-organisations. The main punishable offence Ozdil Investments Ltd. committed was to ignore cautions from non-police agencies. It was stated in the court that 'Death was a virtual certainty for any operative falling from the fragile roof that they were working. Multiple operatives were working on the roof over an extended period, without any full prevention or fall arrest measures in place' (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 20). The category of crime was relatively clear, so the defence could not put forward a strong counterargument against the court:

> **[Judge]:** Thank you. That was going to be my first question. Is there any dispute that it is category A, as far as corporate manslaughter is concerned?
>
> **[Defence]**: It is very difficult to – I hope Your Honour doesn't mind me saying so – it seems incredibly difficult to find anything given the findings of the jury, which would enable me to properly make submissions to try and convince, or to make representations to suggest otherwise (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 23).

#### 6.3.3.1 Finding and punishing the responsible actors within companies

Another critical point relating to applied justice is finding responsible actors (within company) and punishing companies. This issue forms an integral part of the court record (more than ten pages). The discussion of finding and punishing responsible actors can be observed throughout the court discussion over three particular issues: linked organisation, exceptional case and directors. The following sections from the court transcription help to comprehend this issue.

> **Defence [on behalf of Ozdil Investments Ltd]:** The one area clearly where there is some significant decision that Your Honour will need to make is the issue of ***linked organisation***. (…) The directors of investments are all four brothers, and each one of them is a shareholder as I understand it. The position in relation to UK; however, is – I disagree with my learned friend about the directors, the directors from the documentation appear to be Firat and Serhat, not including Bektas. If that matters, I am not suggesting that itself it's a definitive, but certainly there are only two of those directors, one of whom, of course, is not a defendant in this case, ***Bektas is not a director.*** In relation to the ownership of Ozdil UK Ltd, it is Serhat who is the sole shareholder, and that again comes from the documentation which has been provided to Your Honour. I would invite Your Honour to consider that it would be appropriate when deciding whether this is an **exceptional case** and comes within the bracket. […]. The Crown's decision not to indict Ozdil UK suggests that there is an acceptance, both that they are separate companies, and that Ozdil UK ***was not involved in any criminality.*** Again, I suggest that that is not definitive, but it is an important feature***. The Crown took the decision not to prosecute either Serhat or Bektas. Again, I don't say that there may not have been good reason why that was done*** (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 24, author's emphasis).
>
> […] I would respectfully suggest that it is not proper to use the phraseology from the section itself to take into account the resources of Ozdil UK for the following specific reasons: It would be unfair on Ozdil UK as the Crown have not chosen to indict Ozdil UK. ***Serhat was not a defendant as I have indicated, and undoubtedly, he would feel the financial repercussions. These companies are separate entities with linked personalities, but they are not linked companies in the sense of unable to stand alone*** (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 26, author's emphasis).

The defence team emphasised possible adverse effects of custodial punishment on Ozgur Ozdil. They gave some examples from his life, such as the successful management of the family business and learning lessons from this 'tragic accident' to escape disqualification as a director and custodial punishment (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 34). The barrister (on behalf of Firat Ozdil) tried to convince the court that Firat Ozdil is a decent person, has learned his lesson and is not likely to make the same mistakes. The barrister established his argument by mentioning in the report that the lower risk of recidivism was to avoid disqualification from being director and a compensation order (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, pp, 28–30).

Despite the defence's claim that the directors are not linked with the company and the court should consider the issue, the court gave a prison sentence and fine. The reason that led to a lengthy discussion is related to sentencing guidelines for health and safety offences, corporate manslaughter and food safety and hygiene offences, which came into force the 1st of February

2016. The word ‘exceptional’ is placed on a case to determine offence category and punishment in the guideline (Sentencing Council, 2015). The whole statement placed in the guidelines may help to understand this discussion that ‘normally, only information relating to the organisation before the court will be relevant, unless it is demonstrated to the court that the resources of a linked organisation are available and can properly be taken into account’ (Sentencing Council, 2015).

The main focus of the defence was to lower the punishment issued by the court. However, it is difficult to say that the defence achieved this aim.

> Judge: In so far as you are concerned, Mr Ozgur Ozdil, for many of the same reasons you are guilty and at fault in relation to your duties towards Mr Nikolai Valkov. But, as far as you are concerned, I take into account that it was your brother who was in charge, that you only took responsibility when he was out of the country. But I do take into account, as far as you are concerned, that you were the man who negotiated with health and safety, you knew better than anyone else what your duties were, and you chose to ignore those duties. It was down to you to explain and to make sure that your contractor knew his duties, and clearly that wasn't done. […] As far as disqualification is concerned, I direct that both of you be disqualified from being a director for a period of 10 years (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.44)

The Crown prosecution helped the Judge on the last decision by articulating the evidence and the guidelines. The CPS presented reasonable arguments related to the issue of ‘linked organisations’ and whether this case is ‘exceptional’.

> Miss A (CPS): The guideline makes clear that: “By definition the harm and culpability involved in corporate manslaughter will be very serious. Every case will involve death and corporate fault at a high level (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 17)
>
> […] The reason the Crown introduce the state of the finances of Ozdil UK Ltd, is on page 6 of the guideline **[the relevant part was indicated above]** (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 19)
>
> The prosecution's case is that Ozdil UK Ltd is a linked organisation to Ozdil Investments Ltd, such as that it is, essentially, the same company. It is not the Crown's case that those companies are sham companies, we do not say that, but the directors of Ozdil UK Ltd are made up of three of the four directors of Ozdil Investments Ltd, and we say that any distinction is artificial. A sentencing court must be able to look at the wider circumstances of a company and its directors, as to do otherwise would potentially, the Crown say, result in an injustice, and the injustice which would potentially result here is that by way of, essentially, a mechanism and an artificial distinction, Ozdil Investments Ltd would not be ordered to pay a financial penalty which would reflect its means and the means of those behind it (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.19).
>
> The guideline says, "Unless, exceptionally, it is demonstrated to the court." And what we have here is almost identical personnel working from the same premises. Bektas Ozdil, when the incident has taken place which involves Ozdil Investments Ltd, goes and brings the forklift truck that is used from the scene back into Ozdil UK Ltd. There is a wealth of evidence that these companies overlap, and it is for that reason that we make the application in the way that we do. ***I do have to say that we have not been able to find any authority in relation to this point. I suspect that is because these guidelines are relatively new, having only come into force in February 2016, but those are the points that I make and I am happy to return to***

> ***that point, if your Honour would wish me to at any point***? (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.20, author's emphasis).

The focus of this discussion was to convince the court that Ozdil UK is a linked organisation, and the company and its directors should not be punished due to sentencing guidelines. The barrister tried to convince the court to consider the category of harm due to the guidelines. The critical issue regarding this part of the court discussion was the application of new guidelines in this case. The likely factor that led to a lengthy debate on this issue is that the crime agencies did have not enough experience in applying the new punishment rules.

Kadir Kose pleaded guilty to an offence under Section 37 of the Health and Safety at Work Act of 1974 and corporate manslaughter on the 27th of September 2016. Additionally, one of the participants (13/01/2021) revealed that the insurance company paid €350,000 to the worker's family. The crime committed by Koseoglu Metal Works Ltd. was described in the following way in court:

> It caused the death of Mr Valkov, the Crown say, by gross breach of that duty by the way in which its activities were managed and organised. In particular, it failed properly to plan and supervise works taking place on the roof of Ozdil House, it failed to provide suitable and sufficient training to Nikolai Valkov, it failed to supervise work being carried out on the roof Ozdil House, and it failed to ensure appropriate safety measures were in place to minimise the risks associated with working at height. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 4)

Similarly, the jury fined Koseoglu Metal Works Ltd. with the lowest amount due to the sentencing guidelines regarding punishing micro-organisations. At present, Kadir Kose continues to run his business in Europe under a different company. Kadir Kose was sentenced to eight months imprisonment and disqualified from working as a company director for 10 years on the 19th of May 2017 (Pinsent Masons, 2017). The company's barrister made efforts to get lower punishment by indicating that her client is saddened by the tragic event and criticising the guidelines (2016 Sentence Guidelines) that are not cleat and determined harm category is controversial. The relevant part of the discussion quoted below presents the endeavour of the barrister:

> (…) if you are satisfied that that is the appropriate category for Mr Kose, you will see – and it may not help the court – the sentencing options **are vast.** One, that although a bad case, looking at his culpability it cannot be said to be the worst case of its type, and that would invite Your Honour to draw from the one year. Secondly, his mental state of neglect is lower than connivance and consent, it would entitle Your Honour to draw down even further, and at that stage one is then in a position to give whatever credit you regard as appropriate in relation to all guilty pleas. It is those factors, in my submission, which would allow you, perfectly properly and commensurate with your public duty, to impose a custodial sentence because, one, it clears the threshold, two, you think it is unavoidable, but three, not to impose it immediately. My primary submission is that it is not necessary, in the public interest, to send Mr Kose to prison immediately today. **But, if Your Honour was against me on that, then I pray in aid the remaining points that would show that the maximum in this range is one, and there are many powerful reasons from reducing it from that range** [author's emphasis]. I have dealt with that, because there is not much point in dealing with the finances (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, p. 38)

The barrister (on behalf of Kadir Kose) built his defence for changing the category of punishment and keeping it at the lowest level according to the guideline by mentioning his client's duties as a father, being responsible for his children's' education and needs, their low level of income and the inappropriate budget of the company (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, pp. 38–39). However, the court insisted that the owner of the company was guilty of a high level of wrongdoing, and it should be evaluated as corporate manslaughter.

## 6.4 The role of agencies

Looking at the critical agencies' responses to safety crimes helps in understanding their roles in the prosecution process and in securing justice. The performances of the HSE, the CPS and the Police are analysed under this title.

### 6.4.1 The HSE's role

The contribution of the HSE is shown by court hearings and interviews. The Judge carefully considered evidence, such as photographic evidence, communications between parties (the companies, local authorities and the HSE) and witness statements. Most of the evidence was collected by the HSE, which can be asked to provide the CPS or the Police with an opinion on how far on organisation fell below the relevant standard. Inspectors should consider whether they are qualified to provide this opinion and whether specialist inspectors or other experts in the relevant field would be better able to provide an expert opinion (Health and Safety Executive, 2020b). The HSE warned the company that there were potential hazards to the repair work. For instance, a damask should have been set in the working area. In this case, the company (Ozdil Investments) did not apply the required health and safety measurements and take seriously the warn of the HSE. However, Koseoglu Metalworks Ltd. had no history of bad safety, as was highlighted by one of the informants:

> I had been doing this business since 2007–2008 in England before the accident. Neither HSE nor the municipality health and safety department ever said anything to come and said that you should do this business like that or take these measures. In the prosecution process, HSE told me only that you had to learn these measures yourself, research and learn it. I did not have any problems with Health and Safety, or local councils related to my business until this accident (13/01/2021).

As another contribution of the HSE, the professional knowledge of the HSE became critical, which is evident in the court record. The Queen's Counsel made a detailed statement about the HSE inspector's finding:

> He (specialist inspector of the HSE) found that: one, it was known that the roof of Ozdil House was fragile and, therefore, access to such a surface had to be properly planned and appropriate protection measures put in place to control the risks to those at work on it; two, there were no protection measures in place to protect falls, either through or from the edge of the roof, and three, the absence of measures to limit the distance and consequences of the fall showed a fundamental lack of understanding of the principles of fall arrest, such that he considered them to be woefully inadequate. Four, both Ozdil Investments Ltd. and Koseoglu Metal Works Ltd. fell far below the standards expected. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 7)

Concerning this, according to one of the informants (P1), the HSE played a critical role in the final verdict (13/01/2021):

> I mean, the basic factor might be my lawyer: I later realised that the lawyer was not powerful enough. However, when I thought that the other defendants' lawyer is a different one, I could not comment on my lawyer about the given penalty because other defendants took the same penalty event though their lawyer is different. However, HSE is mostly. In my opinion, the most influential institution in getting this punishment was HSE. Yes, I think it was HSE because the institution that forced us was it.

The participant emphasised that the factor that led to the decision resulting in a prison sentence was the HSE's contribution and the ineffectiveness of the defence team by saying that:

> I was not expected to go to court until the last court hearing. I believe that I would not be served time in jail if I'd had an experienced and good lawyer and barrister. They (lawyer and barrister) told me that 'you will not go to prison' until the last minute. Even I attended the last court hearing by thinking that I would not serve time in prison. Before the last hearing, they (lawyer and barrister) stated that just in case, pack your suitcase. However, they said that you would not (60, 70 or even 90 percent) go to prison.
>
> When the police interviewed me, the HSE was always there, recording the interview. They [HSE] generally went with the police to collect evidence or conduct interviews. Even the police and the HSE cross-questioned me at the police station (02/02/2022).

The entire story, including documents and interviews, indicates that the crime agencies played a critical role in securing justice. However, an important question to raise is who allowed these companies to continue these unsafe working conditions, and how this gap was left unfilled, despite all the warnings from the HSE. It appears that the local authorities and the HSE did not ignore the unsafe conditions, as was made evident in court. For instance, according to the CPS:

> The local authority repeated these requirements to the company and telephone calls and emails, before the matter was passed onto the HSE. The HSE reiterated the need to appoint competent contractors and a CDM coordinator in contact by telephone, email and a site visit in November and December of 2013. It was repeated in an email in January 2015. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 15)

These statements were considered a primary reason to charge the companies (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). The knowledge of the case helps us to evaluate the policing strategies (see further discussion Chapter 3.4).

*Table 6-1 The evaluation of policing strategies*

| The policing strategies (P.S.) and key points | The relevant collected data in the case | A reasonable evaluation |
|---|---|---|
| ***Punitive P. S. (Pearce and Tombs, 1998): "severe punishment and regulation."*** | Applied severe punishment: A high amount fine and prison sentence | There is no record of re-offending. |
| ***Reintegrative P. S. (Braithwaite (1984): "communication and the usage of legal power."*** | There was communication between companies and agencies. | It was partly applied because the legal power of agencies was not applied even though there is strong caution. |
| ***Internal P. S. Gray (2006): "worker responsibility."*** | The worker realised the possible harm. | The worker did not act on time. There would be a still risk for other workers. |

***Table 6-1*** shows that the case may be analysed by each of policing strategies. However, it is difficult to say whether any of policing approaches provides a viable solution to prevent safety crime and enable justice. The reason is that any of policing strategies was not accurately applied. For instance, reintegrative policing strategy prioritises communication and the legal power of agencies in preventing crime (Braithwaite 1984). However, the collected evidence shows that agencies did not apply legal force to companies despite a long communication history.

The importance of local authorities in work-related deaths can be observed through the court hearing in this case. The correspondence between the HSE and the companies indicates that the regulatory duties belong to the local authorities, as stated in court:

> Mr King gave evidence that he explained to Ozgur Ozdil **that it was not the HSE who had prohibited the work from being done, it was instead the council. He confirmed this in an email the same day saying, 'I am not aware of any reason why the work on your roof cannot be carried out. Obviously, it will need' – author's emphasis I should say – 'it will need to be carried out in a safe manner by people competent to do the work** (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 15, author's emphasis).

Moreover, it is recorded that the local authorities issued warnings to Ozdil Investments Ltd. related to unsafe working conditions on the 3rd of February 2011 (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). It was considered a poor health and safety record of the company in court.

The analysis of the HSE's role in the case indicates that the HSE played a critical role by warning the companies, collecting various evidence and sharing professional beliefs.

### 6.4.2 The CPS's role

The importance of the role of the CPS is relatively unclear when considering interviews and court discussion. However, it is evident that the CPS contributed to the case on three occasions: 1) In helping to find responsible actors for corporate manslaughter, 2) highlighting evidence and 3) indicating guidelines in court.

In contrast to the prominent contributions of the HSE and the Police to secure justice, there has been deficient information to prove a significant contribution from the CPS. The Judge referred to the CPS a few times in court. One of them is worth mentioning here. The Judge stated that:

> I have heard argument from the prosecution, not necessarily applying to the corporate manslaughter, but it is sensible that I deal with it at the outset in this way. The Crown argue that as far as Ozdil Investments are concerned that is a micro business, or company. But, if I take into account the other company, the soft drinks company, which is Ozdil UK, the Crown urge me to incorporate that as a business that I can take into account when dealing with potential fines and so on. It is, say the Crown, a linked organisation (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, pp. 42–43).

On the one hand, the statement shows that the Judge was decisive in convicting both companies for corporate manslaughter while the CPS did not strictly intend to issue a punishment for corporate manslaughter, contrary to the Judge.

The statement shows the different policing strategies and activities. This difference was pointed out by HSE P1 in the following way that

> (…) obviously**, the coroner has a different objective to us the coroner is looking to find out how the person died, essentially that is their remit, not whose fault, but, how, as you can see, it's a, it's a courtroom where evidence comes out**. So we, from time to time, we'll find something new that comes out through that process that is material to our decision of what failings, we should bring charges it for. So we usually wait, so you can see us on how to change course slightly after that. But equally, you know, if we were to find something, either as a result of the inquest, or through our own investigations that then pointed to corporate manslaughter, **we would need to go back to the Police, and bring that to their attention because it isn't, we are not able to say, yes, we are now investigating corporate manslaughter, that is a decision for them, and it will be done by them** (21/05/2021, author's emphasis).

Levi (1987) described these differences among agencies in investigation and prosecution processes regarding the objectives and making decisions. The argument behind this is practicality and ensuring diverse perspectives from Police and non-police agencies (Levi 1987).

On the other hand, there are some contradictory statements that show that the CPS intended to categorise the wrongdoing as high-level harm and corporate manslaughter in court (Regina v Ozdil Investments Ltd and Koseoglu Metal Works Ltd, 2017, pp.17–20).

In this case, the critical contribution of the CPS was in helping to determine the responsible controlling minds for corporate manslaughter, considering that this issue enlightens the decisions related to linked organisations and whether it is an exceptional case or not.

> MISS A. [CPS]: Mr Taylor, an environmental health officer for Harlow Council, saw three men with no safety equipment working on what was clear to him to be a fragile roof. He told the men to come down and he spoke on that occasion with Ozgur Ozdil, to explain that this was unsafe working. Later the same day a prohibition notice was served upon Mr Ozdil (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.5).: (…). The notification was signed by Ozgur Ozdil at the meeting on the 25th of February 2014 to say that he was aware of his duties under the regulations, and in signing the notification he described himself as manager. ((Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p p.6-7): He *(Firat Ozdil)* said that they, Ozdil Investments Ltd, had provided the materials for the work. That the company were unaware that Koseoglu was using a forklift with a cage attached to the front to get people onto the roof, and the forklift did not belong to Ozdil Investments Ltd. I simply ask your Honour to bear in mind at this stage that it was Mr Bektas Ozdil who drove that forklift into the soft drinks company, Ozdil UK Ltd, and I will come to that a little later. Firat Ozdil said that he was present, but not involved in a meeting that took place in February of 2015 with Kalou, Rayeef and Ozgur, at which safety measures for the work on the roof were discussed, and they left it to the specialists, who had separate meetings without Ozdil Investments Ltd present ((Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.12). (…) Safety measures, such as the use of netting were discussed with Firat Ozdil and Ozgur Ozdil, and one of the Ozdil brothers was always present on site when work was being carried out. (…) the company's interview Firat Ozdil confirmed that there were four brothers, and that they were each director of the company and that there were no other employees; in effect, the company consists only of the senior management. The decisions taken by the company in relation to the work being carried out to the roof of Ozdil House were made by Firat and Ozgur Ozdil in their capacity as directors (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p.14).

The whole court transcription articulates that the primarily responsible managers are Firat and Ozgur Ozdil, rather than other directors (Bektas and Serhat Ozdil). The collected evidence enabled the ‘right’ directors to be found and charged for corporate manslaughter occasioned by the CPS’s statements.

### 6.4.3 The Police’s role

The police investigation contributed to securing justice in this case. The court record revealed important clues related to this role. The Essex police, another critical actor in the Valkov case,

claimed that the Ozdil and Koseoglu companies had obvious faults leading to the accident. Inspector Ian Jennings (Tevlin, 2017) stated that:

> The death of Nikolai Valkov was a completely preventable tragedy which has caused an immeasurable sense of sadness and loss to his family. It was caused by two companies and their directors, who showed a total disregard to their responsibilities to ensure the safety of workers on the site – something which should be of paramount importance. Mr Valkov and his family were failed by Firat and Ozgur Ozdil, Kadir Kose and the companies they ran. And while I hope their conviction will come as some solace to his family, it will not bring Mr Valkov back and that is something his loved ones have to deal with every day.

Despite this is a typical response to a successful case, the Police took the crime seriously. Additionally, the Police contributed to securing justice by collecting evidence and interviewing the owners. The police investigation indicated that there was no professional communication between the companies, which was considered an issue in court (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017). Further, the statement from the company owner to the Police was shared in court to show a lack of knowledge about the safety of the environment. Judge Lynch highlighted this point by saying:

> You had choices and you chose to send Mr Valkov onto that fragile roof with no training, with no safety precautions. And I accept, Mr Kose, that you have pleaded guilty, but even during the course of your interviews with Police you were still denying that he was ever on the roof, so you weren't showing much remorse at that stage, and a man had just died. So, yes, I am sure you all feel very sorry for yourselves, but you to have a long hard look at what you did, and it is no better in retrospect than it was at the time. (Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd., 2017, p. 41)

This statement reveals that the police investigation, which included formal interviewing, affected the Judge's decision in court.

The fundamental contribution of the police to secure justice started with securing the crime scene. The police were the first crime agency to intervene and arrest possible responsible actors. Their duties that followed included gathering evidence, such as CCTV and photographic records, and conducting interviews. One of the people involved in the case pointed out these roles and added that the HSE collaborated with the police to get testimonies and collect evidence (02/02/2022).

## 6.5 Conclusion

The Valkov case represents a successful implementation of the CMCH Act. It is particularly noteworthy because few cases have resulted in a guilty verdict for corporate manslaughter in the UK, despite the frequency of these fatal accidents (see Chapter 5). In the Valkov case, the Police and non-police organisations played a crucial role in shaping the verdict. They paid close attention to the case and argued that there were apparent failings by the companies involved. The way that

agencies responded to this case provides insight to help categorise this crime. This issue will be discussed in Chapter 9.

The prominent agencies in this case were the police, judge, the HSE and the local authority. They each played a role in proving the cautions of the local authority, indicating the companies' records prior to the accident, and communicating with all parties. The statements of HSE professionals were presented in court and contributed to the decision process by showing the level and type of irresponsible attitudes of the companies, such as not taking safety measures and providing inadequate training. The police contributed to the investigation process by gaining witnesses' statements, CCTV records and interviews. The CPS mostly played a role in evaluating the case and sending it to court under the related act.

The analysis shows that the court discussion concentrated on four critical points: (i) the extent of the safety conditions that were or were not provided, (ii) the awareness of the seriousness of events that led to deaths, (iii) the companies' backgrounds in health and safety issues and (iv) the irresponsible behaviours needed to determine the appropriate punishment in the eyes of police and non-police agencies. One of the vital issues in the punishment and inquest process was Koseoglu Metal Works Ltd and Ozdil UK Ltd failing to provide adequate training for their workers. The other was failing to impose safe conditions for workers.

The prominent factors were not only the high-level attention of the HSE and the police, but also the Judge's approach to the actions of the companies. The Judge took a determinative role to consider the companies' acts as corporate manslaughter by applying fines and prison sentences without suspending the sentences, reflecting a serious perception of crime.

As another characteristic of the case, it is evident in the court discussion that the CMCH Act highlighted many of the failings stated above to charge companies with corporate manslaughter. Considering applied justice, this finding suggests that the effectiveness of the CMCH Act (see Chapter 2) needs to be reconsidered, at least in this case. Parsons (2018) claims that like other convicted cases of corporate manslaughter, this case does not provide insight to understand how senior management test applied in practice considering corporations' negligence instead of individuals' negligence.

In Chapter 7, I will determine the factors that made the investigation process unsuccessful and affected the definition of the companies' actions as not guilty for corporate manslaughter and the role of agencies in the prosecution processes. The analysis of a second case study will contribute to answering the second and third research questions (see Chapter 1). In Chapter 9, the findings from these two case studies allow me to propose precise answers to these two questions.

# Chapter 7 The Gleision Colliery Mining Tragedy (MNS Mining Ltd)

## 7.1 Introduction

Chapter 5 helps to classify five different results of the prosecution and punishment processes for WRDs. One instance (guilty decision of corporate manslaughter) of first type (cases investigated under corporate manslaughter law) was analysed through the first case study (see Chapter 6). The MNS Mining case represents another instance (not-guilty decision of corporate manslaughter) of the first type which means agencies decided that the disaster occurred accidentally rather than because of the company's negligent action. The second case study focuses on the Gleision Colliery (MNS Mining) case, which has crucial implications for identifying the characteristics of not guilty verdict cases in the UK. It represents an unsuccessful application of the CMCH Act.

The case was the first instance of charging a non-company manager for corporate manslaughter, and there was also an opportunity to test the culpability of the senior manager under the corporate criminal act (Tombs, 2018). Swansea Crown Court found the company not guilty of corporate manslaughter. This, in turn, allows us to determine whether it was a factor in securing justice during the prosecution process. The findings of this case study are also critical to the discussion of theoretical debates, such as those concerning safety crime policing, corporate criminal liability and the effectiveness of the CMCH Act (see Chapters 2 and 3). Additionally, this case remains crucial for families and appears in mass and local media (Morris, 2021; Skidmore, 2021).

The main aim of this chapter is to explain what factors helped the jury make their decision and how the actors granted the case. This chapter focusses on how agencies applied the new law and which issues were important for them. Additionally, I aim to determine the agencies' roles in the verdict. The analysis of this case provides insights into the rationales and factors underpinning the not guilty decision. In contrast, the first case study (that of Nikolai Valkov) provides insights into the reasons and factors underpinning the guilty verdict for corporate manslaughter.

I analysed various data using documentary analysis, and addressed the roles of key actors and the key themes. I focused on the 'water issue', experts' testimony in hydrology and other relevant areas, except for the scrutiny of the evidence and events that were thought to have led to the incident. Additionally, the professionals' discourses show that they approached the accident in a technical way rather than as part of a criminal investigation (see Chapter 4).

The investigation process and the determination of the final verdict indicate the third party's role in the decision (in this instance, the professionals' ideas about how the case occurred and who might be responsible for the action that led to the deaths). It seems the views of the jury and the experts played pivotal roles in this case. Considering these factors may help to explain problematic issues with the CMCH Act.

## 7.2 Background

The event happened on the 15th of September 2011 at a drift mine in Cilybebyll, Wales. Charles Breslin, Philip Hill, Garry Jenkins and David Powell died in the mine. The mining organisation was accused of four offences, and the mine manager was put on trial.

Analysis of the case is complicated by technical issues and the various actors' approaches. Therefore, the background information about the area where the accident occurred, the company and the people involved in the case may help to reader in understanding of these issues. First, I will present key information related to the scene and people. I want to direct your attention to places in the accident area, such as the (old) south-eastern workings, H1 towards the roadway and central workings, the central workings, the underground water and the main drift entrances. *Figures 7.1 and 7.2* outline these areas. The water issue was discussed around these places to understand where the water came from and accumulated.

**[REDACTED]**

*Figure 7-1 Gleision Mine (Morris, 2014)*

The documentary data collected indicate that the water issue was known in 2011. The history of the mining area shows that the active extraction areas were north-east of the main drift, and previous work had been completed in a north-easterly direction in the 1980s (Health and Safety Executive, 2015a).

The following section provides a list of actors, including their roles and jobs, to help understand the analysis of this complicated case.

### 7.2.1 The history of events connected to the accident

This section provides an overview of the mine area and the accident. According to the HSE, eight people, including one supervisor and one manager, usually worked for the company, and the company had traditionally been mining for coal (Health and Safety Executive, 2015a).

| Actors Who Had Roles in the Court Discussion | | |
|---|---|---|
| **Dr Pritchard** | Handwriting expert | Checked Mr Fyfield's handwritten notes |
| **Dr Alan Cobb** | Expert in hydrology | Identified where the water came from |
| **Mr Rees** | HSE inspector | Identified whether the Provision and Use of Work Equipment Regulations 1998 (PUWER) application was discussed with the manager |
| **Tony Forster** | HSE inspector | Performed an inspection for Gleision in May 2010 (the last inspection before the incident on the 15th of September) |
| **Mr Matik** | Manager before the 4th of July 2011 | |
| **Adam Anthony** | Expert | Completed the laser survey to calculate the amount of water and distance |
| **Mr Yoxhall** | HSE inspector | Performed an inspection on the day of the accident |
| **Mr Arthur** | Worker | Recollected the events on the day of the accident |
| **Mr Wyatt** | Worker | Recollected the events on the day of the accident |
| **Peter Jones** | Rescue team | Investigated the mine on the day of the accident |
| **Brian Thomas** | Rescue team | Investigated the mine on the day of the accident |

*Table 7-1 The role of important actors in the court*

Following a routine blasting operation, the tunnel in which the miners were working began to fill up with 500,000 gallons of water. The tragedy occurred while seven miners were working with explosives on a narrow coal seam. Three miners escaped, one of whom was taken to hospital with life-threatening injuries, and the others were trapped underground. Despite the efforts of the rescue team, the miners were found deceased the following day.

The news reports and court hearings indicate that the main reason for the deaths was the tunnel filling up with thousands of gallons of water. The court records show that the manager knew about the water issue before the 4th of July 2011 (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014). The judge started the court case by examining the water issue:

> Both Mr Matik and Mr Fyfield agree that they had a conversation about water within the mine and both of them agree what it was about, because they agree that Matik directed Mr Fyfield's attention to the fact that there was accumulated water in the Old South-Eastern Workings. (…) Mr Fyfield began to form ideas for the development of the mine, and he reached the conclusion that driving a stall to connect H1 with the Old Central Workings would be a good thing to do. He said:
>
> 'It would create much better ventilation, a new means of access and egress from the mine and a new area would be opened up for coal mining.'
>
> At about the same stage, so he told you[jury], he began to consider that the plan to drive H1 into the South-Eastern Workings wasn't feasible. He told you that it would have required very significant additional equipment and, in short, he thought it just wasn't practicable.
>
> Now, at some stage **Mr Fyfield drew a sketch** on what you know as the 'torn' plan and there's the original of it right in front of you. You've got a copy at your page 187 and **there's, that sketch appears to show a stall making contact with the Old Central Workings with working stalls to the west and east of it. Mr Fyfield accepts that he drew that sketch, and he also wrote the words:**
>
> **'Water'** (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 4–5, author's emphasis).

These comments show that the water issue was on the managers' agenda before the accident, and the managers devised a relevant plan. It is likely to say that Mr Fyfield knew there was a possible risk of water being in the central workings. The following statement may be evaluated as an admission of responsibility for this action:

> He [Mr Fyfield] told you [the jury] that he did this in the first few weeks after becoming the manager and it was his attempt to fix the water line on the information which was then available to him. He stressed, however, that this line was drawn before he carried out any of the three inspections which he said he made in the Old Central Workings. (…) It was in these early weeks, too, that Mr Fyfield decided to change some of the working practices which had been carried on in the mine. He told you, for example, that he decided to change the support rules and you know that he produced support rules for working in what became the store leading from H1 to the Old Central Workings (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 5).

However, Mr Hill (one of the workers who died) possibly prevented these changes from being made according to court hearing: '[…] but it seems as if Mr Fyfield was trying to impose his own ideas about how the men should be deployed in their work and that Mr Hill was somewhat resistant to Mr Fyfield's proposed changes'(R v MNS Mining Ltd and Malcolm Fyfield, 2014, p. 6).

Our knowledge consisted of the HSE report, court hearing and news reports which show that one week before the disaster, Malcolm Fyfield was cautioned by the outgoing mine manager Ray Thomas and Alun Rees (the Council planning chief) about an issue related to the subterranean water (Channel 4, 2014).

This issue was also mentioned in court (for further information, see the discussion in Section 7.3.1). Further, Mr Fyfield stated, 'I investigated the area at the beginning of September, even before the day of the accident, I did not see any sign of [a] water leak even though there were "some puddles"' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 12).

### 7.2.2 The accident and the events

The day of the accident and its aftermath help us to examine the case from various perspectives. The court hearing and the HSE report present a detailed explanation.

According to the manager's and witnesses' statements, there were almost no unexpected events on the 14th of September 2011; two incidents of mining blasting occurred, and the manager checked the mine a few times. However, a critical situation was described in court:

> **Now, when that drilling operation happened, water came through on the stall side and Mr Hill called Mr Wyatt to show him the water.** The hole made by the men was either 2 or 3 inches in diameter and the water coming through the hole was described by Mr Wyatt as **being like water coming through a tap when the tap is half on or half off. Mr Wyatt watched this for a few seconds, then had a short conversation with Mr Hill, in which Mr Hill assured him that everything was all righ**t. Mr Fyfield was told of this event that afternoon, according to the evidence he gave you. It didn't concern him either. It didn't concern him and, apparently, it didn't concern the men working at the face. **Mr Fyfield had intended to go back into the mine in the afternoon, before blasting, but, as you know, he told you that did not happen** (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 12, author's emphasis).

Some questions arise here that relate to this part of the discussion:

1) Did Mr Hill have enough knowledge to decide whether 'everything was all right'?
2) Despite Mr Fyfield knowing the situation, why was he not worried by the preliminary warning?
3) Why did the court not deem this to be negligence?

The first question remains unanswered. The possible answer to the second question is that Mr Fyfield ignored the warning. The analysis shows that this act was not sufficiently proven, but the CPS and HSE highlighted it in court.

The day of the accident was explained in detail in court. This part of the discussion will help readers to understand the position of the manager and workers, where exactly the accident happened and what they did:

> On 15 September, Mr Fyfield got to work shortly after 6am that morning. At about 7am the men working at the mine arrived for work. They were the four men who died. Nigel Evans, David Wyatt and Andrew Giles, all of the men went underground, with the exception of Mr Giles, who remained at the surface. Underground, Mr Evans took up his work position, which was at the junction of the Main Drift and H1. You will remember that it was his job to operate the conveyor belts along the Main Drift and H1. Mr Wyatt went to his workstation, which was at the junction at H1 and the working stall.

> The three men at the face were Mr Hill, Mr Powell and Mr Breslin and Mr Jenkins was deployed to work in H1, approximately 10 metres further on to the east than the opening which the men used to get into the working stall. The men carried on their various duties for approximately two hours. The men at the face were engaged in shovelling loose coal onto the conveyor so that it could be taken by the belt system up from the face to the surface. That loose coal, of course, had been created by the blast the previous afternoon. By around 9am Mr Hill was ready to fire the round of explosives which he had positioned in the face. [..] Shortly before Mr Hill fired the shots, Mr Fyfield appeared underground. He went into the stall in order to have a conversation with the men who were working at the face and immediately became aware that Mr Hill was about to fire the explosives. He didn't stop him. All the men in the stall took up positions which, no doubt, they all believed were reasonably safe. According to Mr Fyfield they were all protecting themselves by either kneeling or crouching behind the cogs (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 13–14).

After the flood, four workers – Philip Hill, David Powell, Charles Breslin and Garry Jenkins – drowned in the gallons of water. The manager was rescued, but he suffered severe injuries to some parts of his body (Health and Safety Executive, 2015a).

The day's narrative was similarly articulated in the HSE's report. The report includes details of the workers' places and the reaction of workers.

Furthermore, the HSE reported that 'At 12.55 pm, a rescue team wearing breathing apparatus re-entered the mine to resume the search for survivors, (…) they had reached a point in the Old Central Workings beyond which they could not proceed because of the water and silt' (Health and Safety Executive, 2015a, p. 6). This detail shows that the amount of water that filled the mine was so large that it prevented the rescue teams from working. It also shows how vital it is to understand where this amount of water came from.

### 7.2.3 The characteristics of the company

Two more massive drift mines were being operated by two companies in the area, one of which had 300 workers and the other had 160 workers (Gorton and Stevens, 2011). This mining area was very active. Interestingly, the applicant withdrew a subsequent application in 2010 regarding surface water arrangements and mitigation measures (Gorton and Stevens, 2011).

MNS Mining Ltd used the mine in which the accident occurred that led to the deaths of Charles Breslin, Philip Hill, Garry Jenkins and David Powell. Gerald Ward and Maria Nora Seage are directors of MNS Mining Ltd, which was incorporated on the 24th of July 2009, and Graham Stephens is one of the company's shareholders. According to official records, the company is still active (Companies House, 2020b). The HSE's record states, 'In the five years before the incident, coal production was intermittent, ownership changed three times and there were five different mine managers' (Health and Safety Executive, 2015a, p.1). Although Malcolm Fyfield was not one

of the company's directors, he was arrested instead of Gerald Ward or Maria Nora Seage. The company is considered a small company. Malcolm Fyfield's position was described in court:

> Mr Fyfield described himself as a hands-on manager. Some of the men from whom you heard evidence, Mr Wyatt, Mr Evans and Mr Giles, attested to the fact that Mr Fyfield was often busy working with the men in the mine and without saying so expressly painted a picture, you may think, which accorded with Mr Fyfield's own description of his work in the mine (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 11).

The company retained an experienced and professional legal firm, which significantly advantaged the company.

A detailed map of the mine is included below (Figure 7.2) to help understand the court's investigation and the role of different agencies.

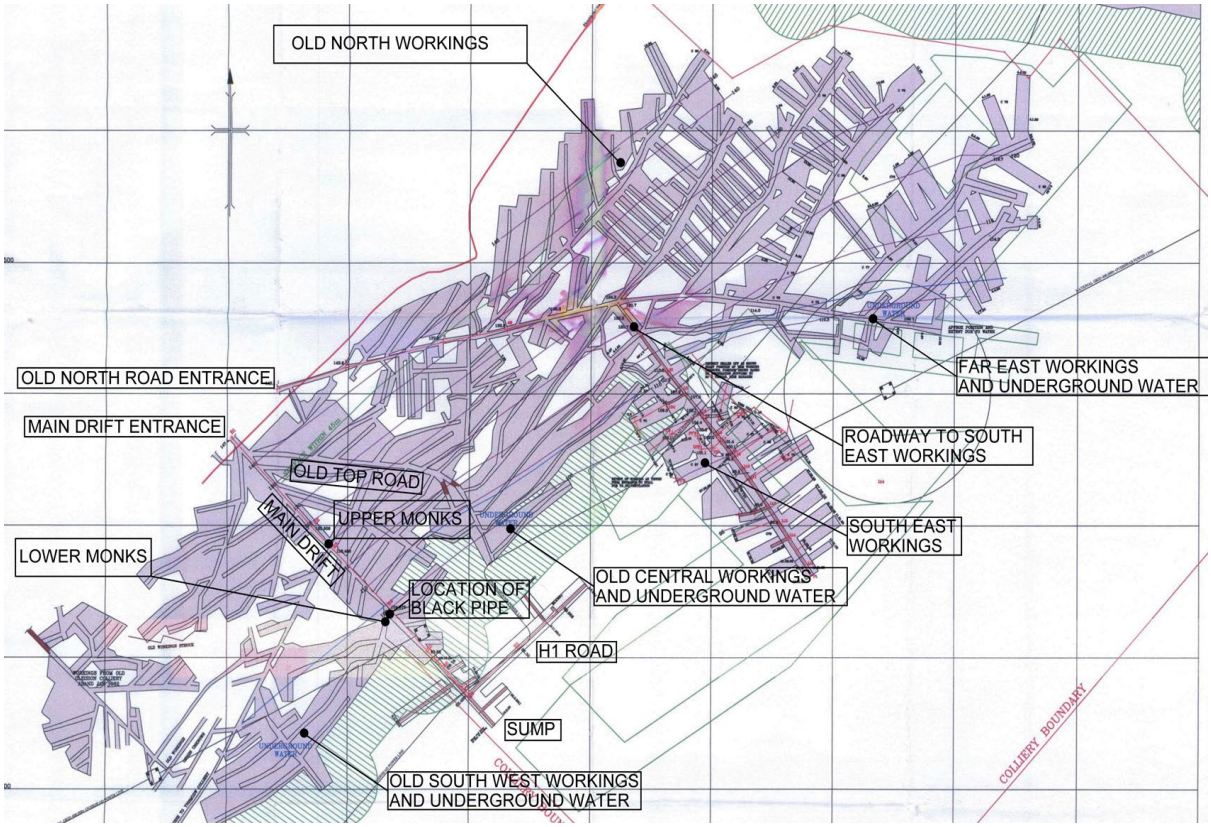



***Figure 7-2 Mine Map[7] (Health and Safety Executive, 2015a)***

The green shaded area is the 'cautionary zone', which was an unused mining area, and the blue shaded areas are the 'underground water', which was divided into three areas: 'the Old South-

[7] This material is re-used under the terms of the Government Open Licence, see the link: https://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

West Workings, the Old Central Workings and the Far-East Workings' (Health and Safety Executive, 2015a, p. 2).

Police and non-police agencies investigated and prosecuted this case, including the CPS, South Wales Police and the HSE. The following section will scrutinise these agencies' roles in the investigative and prosecution processes.

## 7.3 The role of agencies and third parties

The investigation process played a role in the final verdict. The mining area, after the incident, created challenges for agencies that wanted to investigate the scene. This is evident from the HSE's report and professionals' statements that were read in court. The HSE described the prosecution of the accident scene as 'extremely challenging' (Health and Safety Executive, 2015a, p. 8).

### 7.3.1 The HSE's role

I sought to establish how the HSE investigated the case and the company. The court hearing and the HSE's report were the primary sources to understand this role. I analysed these documents to gain insights into a non-police agency's role in the case. The HSE worked for many months to provide an overview related to the operation of the mine on the day of the accident (Health and Safety Executive, 2015a).

It is helpful to start by analysing the HSE's routine duties. The judge drew the jury's attention to a meeting between Mr Fyfield and Mr Rees that was held on the 24th of August 2011:

> He [Mr Rees] said that when the two men were together in the office, he noticed the mine plan and it, that it had markings on it and the markings demonstrated an intention to create a stall leading from H1 to the Old Central Workings. According to Mr Rees, he made a very specific enquiry of Mr Fyfield as to whether or not he had made a PUWER application. According to Mr Rees, he, he used words something like:
>
> He said: 'Mr Fyfield replied that he had.'
>
> Mr Rees told you that he followed this up by asking whether or not Mr Fyfield had notified the Mines Inspector and Mr Fyfield that he had done so.
>
> 'Have you got your proportions from inrushes in place?'
>
> Mr Rees told you that he followed this up by asking whether or not Mr Fyfield had notified the Mines Inspector and Mr Fyfield that he had done so (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 6).

Although Mr Fyfield was advised about this situation, the company did not take the necessary measures. This shows how an action resulting from someone not taking a high level of

responsibility can lead to severe harm. As discussed earlier in the literature review, companies tend to ignore agencies' cautions for reasons that include time and money (Pearce and Tombs, 1998). This explanatory example supports this argument.

However, the defence team presented a counterargument to Mr Rees's claims (see the title 6.2.4. (Lawyers):

> Mr Rees also told you that he noticed Mr Fyfield's black line on the mine plan and according to Mr Rees, in his evidence to you, Mr Fyfield told him that he had produced that black line after going into the Old Central Workings to inspect where the water was lying. In other words, Mr Rees's evidence was that Mr Fyfield told him that the black line had been put on the plan after a visual inspection of the Old Central Workings had occurred (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 7).

This narrative provides explanations for the following queries: whether Mr Fyfield knew of a possible water problem prior to the accident and whether he knew where the water had accumulated.

The HSE stated another critical finding: 'There is a blue line drawn on the plan in the Old Central area. This corresponded to the level of the water in the old workings immediately before the inrush' (Health and Safety Executive, 2015a, pp. 2–3). Additionally, the HSE concluded that 'The site investigation team did not find any evidence at the mine of an assessment of inrush hazards or precautions to be taken to guard against the risks from inrushes' (Health and Safety Executive, 2015a, p. 11).

From the data collected, it is unclear whether the HSE fulfilled its duties. No agency checked that the HSE or the local authority had completed each necessary investigation prior to the accident. It is evident in the court hearing that 'He (Tony Forster) last inspected Gleision before 15 September in May 2010, although he told you that he tried to make an inspection in the winter of 2010/11 but was thwarted by the weather' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 20). Another issue is that Mr Foster should not have been appointed to conduct this inspection due to regulations. This was discussed in court: 'Generally speaking, an inspector who has been responsible for inspecting a particular mine would not be appointed to investigate an accident at that mine' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 20).

However, Mr Steven Denton considered Mr Forster an appropriate candidate for the job due to his knowledge of the area and his experience in the Gleision mine (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014). The following part of the court discussion indicates the unexamined areas of the mine:

> Judge: Mr Forster accepted that he had not examined the areas, either to the west or the east of the Main Drift, nor, to any extent, the area to the north of H1, apart, of course, for the inrush stall itself (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 24).

The HSE investigators found some modifications that differed from the mine plan, and it recorded these changes in the report These changes are only relevant to our analysis because non-police agencies did not identify these changes before the incident.

The HSE inspectors found that the flood of water caused almost no damage to the inrush stall, and other parts of the construction were impaired on the right of the stall (Health and Safety Executive, 2015a). However, this finding raises uncertainty about the water issue, and it is therefore not easy to establish that the HSE made a positive contribution to the case. Another finding supports this argument. As mentioned above, neither the HSE nor the local authority investigated the entire mining area before or after the incident. Further, neither the HSE nor the police investigated some parts of the mine after the incident but instead the court relied on the HSE's findings (Health and Safety Executive, 2015a, p. 17):

> [It is] unlikely that further exploration of the other stalls worked from the H1 roadway and Main Drift areas would yield any relevant evidence, as there was no evidence that any significant amount of water had flowed from them.

The HSE's approach and contribution to the case can be observed in the report regarding achieving an inaccurate result:

> These calculations could only be approximate as they excluded a number of variables that could not be determined, such as:
>
> - whether the water in the Old Central Workings was at the level indicated by the tide marks in the Top Road, or at some other lower level;
> - the amount of roof lowering in the flooded workings above the breach;
> - the amount of depression of the water level in H1 due to the compression of the air trapped beyond its junction with the bottom of the inrush stall.
>
> However, the approximate calculations suggested the amount of water that ended up in the bottom-most parts of the mine was similar to the amount of water that could have been in the Old Central Workings above the breach before the inrush (Health and Safety Executive, 2015a, pp. 17–19).

As discussed above, the HSE did not fully help to identify whether Mr Fyfield or the company's actions led to the accident. In the Nikolai Valkov case (see Chapter 6), the HSE's findings and arguments relied on irrefutable evidence, and in addition to this, the HSE investigated the crime scene and companies before and after the accident. However, in the MNS Mining case, the HSE's findings relied on possibilities, however, including the changes found by the HSE, and these possibilities were not discussed within the criminal justice system.

### 7.3.2 The CPS's role

The CPS made two explicit contributions to the case. The first contribution was to ensure that the case was evaluated in court under the CMCH Act. The CPS considered public interest to be an

essential factor with regard to sending the case to court. Some law firms mentioned the CPS's role in this case, for instance, McKenna and Olswang (2014) explained:

> It was alleged that the mine manager, Malcolm Fyfield, caused the deaths of the four miners by mining into old, previously flooded mine workings, contrary to safety regulations. As such, he has been charged with four counts of gross negligence manslaughter.

The CPS's second contribution was that it intended to sentence MNS Mining under the CMCH Act. This intention was articulated throughout the court hearing, and some relevant parts of the court discussion are worth mentioning here:

> **Judge:** Mr Taylor (CPS) submits to you that despite what Mr Ms Evans (Lawyer) says, you should regard Mr Rees as a witness of truth.
>
> During the course of cross-examining Mr Fyfield, Mr Taylor asked him why it was that he made no mention of this inspection to Mr Rees when they met on 26 August and Mr Fyfield acknowledged that he didn't mention it to Mr Rees when they met that day. His explanation was that there'd been a traffic accident in the vicinity of Tesco's. Neither man wanted to spend any time chatting. There was a handover of the plan, and then they both departed (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 8–10).

These statements indicate that the CPS tried to convince the jury of the accuracy of Mr Rees's explanation. The CPS drew the court's attention to negligence with regard to the investigation of the mining area by questioning Mr Fyfield about why there was no examination of the working stall. Additionally, the CPS stated:

> **Judge:** (…) Mr Taylor also asked him why he didn't check with Mr Hill that he was going to fire single shots. Mr Fyfield's answer to that was:
>
> 'There was no time; virtually as soon as I was in the stall, it was clear that the firing was going to take place.'
>
> No doubt you will make an assessment of those answers. Within seconds of Mr Hill firing, the inrush occurred. Mr Fyfield's estimate is that about 15 seconds elapsed between the firing and the first sign of water. The precise length of time which elapsed is neither here nor there because everyone accepts it happened very quickly.
>
> Now, in his closing speech and by necessary inference in his cross-examination, Mr Taylor was suggesting that all these were merely theoretical or truly fanciful possibilities (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 14, 32).

An inspection of the entire mine was essential to understand the water problem as the condition of the mine did not provide insights into whether the water had come from a particular part of the mine. The HSE brought attention to this issue (Health and Safety Executive, 2015a, p. 4):

> Most of the water found within the mine seeps down from the surface through the sandstone and drips from the roof of the mine workings. This means that the amount of water seeping into the mine will have increased over the years as more coal was extracted and hence more sandstone roof exposed. The flow rate into the mine workings is also known to vary with rainfall.

This can be evaluated as an important finding because the evidence related to the place where the water came from was not obvious. Moreover, this finding was not discussed in court, despite this being critical to scrutinising why the company and/or Mr Fyfield did not consider this option and take appropriate measures.

### 7.3.3 The Police's role

Although the police did not play a pivotal role, they paid close attention to the case to secure justice. The police used their power to arrest the manager based on preliminary knowledge and the evidence collected, and they performed a joint investigation of the mining area with the HSE. Further, the police conducted interviews with all relevant individuals.

Initially, the police arrested Malcolm Fyfield on the assumption that he (as a responsible actor on behalf of the company) might be guilty of corporate manslaughter, which led to the deaths of four coal mine workers (Jones, 2011). After the inquiry, South Wales Police released Malcolm Fyfield on bail, but the interviews recorded with Fyfield were considered in court. According to the court record, Detective Sergeant Griffiths forced Mr Fyfield and it seems detective was not very kind while conducting telephone interview.

Mr Fyfield's experience with the police was also discussed in court (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 36):

> On 18 October, Mr Fyfield was arrested. He was, by any stretch of the imagination, extremely upset. He was taken to Port Talbot Police Station. He was held overnight and until quite late the next evening. There were many interviews under caution over the course of the 18th and 19 October. […]You will see that at that stage, at some stage, because it was never identified precisely when, Mr Fyfield drew the line on P45 to make it absolutely clear where he said he had gone in order to inspect. There could have been no doubt about it, once he drew that line, if there was any doubt before.
>
> Four or five months went by. There were further interviews under caution in March 2012. Mr Fyfield maintained a consistent account through all, throughout that process. Obviously, as I've said, you must take that into account when assessing the credibility of his account.

The primary roles of the police are to conduct interviews and collect evidence using their legal power. In this case, the police evaluated critical points that were raised by other agencies, and they collaborated with the HSE and CPS from the beginning to the end of the investigation (Health and Safety Executive, 2015a; Jones, 2011). The HSE report illustrates that the HSE supported the police's further investigation into and discussion about the necessity of further prosecution for the mine (Health and Safety Executive 2015a). An example of this collaboration can be found in the HSE report (Health and Safety Executive, 2015a, p. 17):

> Although the roof of accessible parts of the Old Central Workings above the breach was generally sound, gaining access to these areas would have required a great deal of work to

> make them safe, and to clear suffocating gases where oxygen levels were low. This would even then have only provided access to a small fraction of the total area excavated over the life of the mine, the remainder being obscured by the stone packs built over time.

The decision that there was 'no need [for] further investigation for some parts of mine' and whether the police had ample knowledge and evidence to make this decision should be questioned. Based on this, it is likely that the HSE influenced the police's decision.

### 7.3.4 The lawyers' role

The defence team was relatively effective in terms of influencing the final verdicts, as they found gaps in the witnesses' statements and convinced the court that the evidence and statements were unclear. The company's law firm and Mr Fyfield's lawyer were reputable and professional in terms of WRD cases. For instance, Elwen Evans, QC, Malcolm Fyfield's lawyer, is head of the law school at Swansea University and a commissioner for the Commission on Justice in Wales (as of May 2020).

One of the arguments presented by the defence team highlighted that the investigation process was inadequate. Evans stated in the trial that some parts of the mine were not adequately controlled afterwards (Channel 4, 2014), and the defence team disproved the claims of the council planning officer:

> **Judge:** Now, Ms Evans made the point that if Ms Mr Fyfield did carry out inspections of the Old area as he told you he did, or at least that is a possibility which you cannot discount, it may be that Mr Rees's evidence becomes less important because if you accept what Mr Fyfield has to say or you think, at least, it may be right the meeting with Mr Rees occurred before any inspections took place and so that dispute might dissolve into something of far less significance (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 8).

Another point made by the defence team was to counter Mr Rees's statements. The following relevant part of the court discussion can help us understand the role of the lawyers (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 7, author's emphasis):

> Judge: Ms Evans, I'm sorry, made a number of criticisms about Mr Rees's evidence. **First, she reminded you that he'd never made any kind of written record of any of this conversation, notwithstanding that it occurred in the context of an official visit to the mine.** Second, Mr Rees's evidence about Mr Fyfield telling him that he had produced a black line after inspecting was at variance with Mr Rees's witness statement to the police. In his witness statement to the police, Mr Rees had said that he had assumed that Mr Fyfield had carried out an inspection before putting the black line on the plan and, indeed, Mr Rees, in the interview, which preceded the making of his statement, used that very phrase:
>
> 'I assumed that he'd inspected.'
>
> That, submitted [by] Ms Evans, was materially different from the evidence given by Mr Rees and, as I've directed you before, inconsistencies of that kind should be taken into account in assessing the accuracy and the reliability of the witness's evidence.

> Ms Evans also invited you to accept that Mr Rees had a motive for giving an untruthful account of this conversation. She submitted to you that Mr Rees was extremely conscious that he was the last person from a regulatory agency to visit the Gleision mine before 15 September and Mr Rees, so she submitted, was making it appear as if he had made relevant enquiries so as to safeguard his own position.

The lawyer built her defence on the weakness of the evidence by addressing statements made by the inspector that are not based on a written or digital record and by scrutinising the honesty of the inspector.

It is likely that the lawyers drew the court's attention to Mr Foster's statements and his difficulty in being objective (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 20–21): 'Mr Reynolds told you that when he was in the process of making his witness statement, Mr Forster told him that he should play down the qualities and experience of Mr Forster, of Mr Fyfield'. Furthermore, the defence team stressed weaknesses in the investigation process and Mr Forster's weaknesses:

> **Judge:** I'm sure that Ms Evans asked Mr Forster a great many questions about how he was appointed, whether he was capable of objectivity, to what extent he had been pressurised by politicians or the press and matters relating to all those issues.
>
> And one that you can safely discount in the light of the evidence upon which the prosecution [relies]. The defence [submits] that there is a complete answer to each of those points.
>
> 'The evidence of the mine managers'
>
> They submit:
>
> 'Is wholly unreliable, self-contradictory in parts and internally inconsistent. The evidence of the water marks in the Top Road can be explained quite satisfactorily by the evidence given by the Mines Rescue personnel. That there was a substantial volume of water at or about the point of the water marks, hours after the inrush occurred.'
>
> Mr Forster's examinations of the area to the north of the breach point did not include any areas to the east of the breach point and, as I will remind you in a moment, Dr Cobb advances the possibility that the source of the water was the South-Eastern Workings, and the defence [submits] that it is simply incredible that Mr Fyfield could have inspected in the wrong location on three separate occasions as the prosecution [alleges]. The mine plan was not difficult to follow for an experienced manager like Mr Fyfield:
>
> 'He would be bound to know where he was' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 24, 29–30).

Considering the lawyers' defence regarding the HSE inspector's investigation, these statements may have confused the jurors during their decision-making process. Therefore, the performance of the defence team can be evaluated as successful and effective with regard to influencing the final verdict of not guilty. This issue was discussed in the literature review (see titles 3.2 and 3.3). Punch (2000) mentioned the importance of having a professional lawyer in escaping from punishment. This disaster captured the attention of the public, the media and politicians. For instance, Neath Labour MP Peter Hain launched a charity fund for the deceased's families, which raised around £1 million (Daily Record, 2013). The Coal Industry Social Welfare Organisation and

Prince Charles supported the charity and the families of the victims. In addition, the Welsh rugby team dedicated their win in a World Cup match against Samoa on the 18th of September 2011 to the miners' families and the poem 'Gleision', which was a reflection on the accident, was composed by Welsh poet laureate Gwyneth Lewis. This gives us an insight into the media attention, but this was not a significant factor in terms of considering workplace deaths as corporate manslaughter in this case. However, the media attention may have been an important part of establishing public interest in opening a criminal prosecution under corporate crime law.

## 7.4 Court prosecution

I analysed discourses presented in court by focusing on the evidence, the judge's approach to the case and conflicts that led to the verdict of not guilty.

### 7.4.1 Collected evidence

In this section, I evaluated both clear and unclear evidence and witnesses' testimonies that were presented by agencies as part of the court discussion and in the HSE's report.

The first example of Mr Fyfield's and the company's negligence is that Mr Fyfield had not made a PUWER application and had informed Mr Rees about the water level in the mine (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014).

Another issue discussed concerns changes made by Mr Fyfield to the stall around H1 and the old central workings, some of which were addressed in the HSE report (see Health and Safety Executive, 2015a, p. 12).

The fact that it is unclear whether a PUWER application was made clearly indicates that someone was not paying enough attention to health and safety regulations, which may have created an environment in which crimes could be committed. This reminds us of Punch's (1996) definition of corporate crime (for more information, see the discussion in Chapter 3 Section 3.2). Punch highlighted specific types of corporate crime, such as 'employee deviance' and 'managerial deviance', which derive from ignorance of the rules. This finding illustrates the importance of a lack of established standards or implemented safety rules, which may have led to corporate violence.

It is likely that the court paid attention to Mr Forster's investigation, which was conducted after the incident in the area that included the main draft and H1 and the area from H1 to the mouth of the working or inrush stall, which was only slightly damaged. The judge described this part of the investigation as follows:

> Mr Forster examined an area of H1 which was beyond the entrance to the inrush stall. He discovered a black mark on the left-hand side of the roadway which he thought was a water mark. (…) Mr Forster could find no evidence that the water had gone beyond that water mark.
>
> On 21 September, he went to inspect the old Top Road (...) Mr Forster's evidence was that the roof in the old Top Road was in good condition throughout its whole length (…) Let me stress that that laser line, of course, is a reconstruction, but no one has suggested that the line does not accurately reflect where the water marks were seen by Mr Forster and I will return to the significance of those marks in a little while (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 21–22).

It is challenging to say that Mr Forster's investigation helped provide reliable answers about the water issue. The judge asked Mr Forster about this issue, and his response was clear: 'My exploration was limited, but I found no tracks of water above the basin area which was immediately beyond the breach point' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 23). Accordingly, the judge emphasised Mr Jones's and Mr Thomas's observations about the volume of water that filled the mine and how it affected the investigation process. Both Mr Jones and Mr Thomas said they could proceed 30 to 40 metres from the main draft to H1.

The judge mentioned the importance of these findings:

> The letters FAB is the Fresh Air Base that Mr Jones set up during the course of his visit to the Top Road. The words blockage and water represent the point beyond which Mr Thomas was unable to travel by reason, so he told you, of the presence of the water in the road.
>
> If Mr Thomas is accurate, he was prevented from going down the length of the top road by the presence of water. Where did it come from? It wasn't there, clearly, when Mr Fyfield escaped, it couldn't have been and so, accordingly, it wasn't part of the inrush. If Mr Thomas is accurate, the only explanation appears to be that another significant amount of water had travelled to this location and it was being prevented from dispersing throughout the mine. The defence [relies] upon that point for obvious reason (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 17).

It seems that Mr Jones's and Mr Thomas's explanations support Mr Fyfield's statements about his exit from the mine on the day of the incident, and the defence team used this finding as supportive evidence. However, the CPS did not agree with this finding and asked the jury not to believe it.

Similarly, one of the inspections did not contribute to securing justice. One of the mine's rescue officers, Mr Lundsman, indicated that there were no crucial findings (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 24). However, Mr Forster's note[8] (written on the 19th of October 2001) included an exciting point:

> Method of working reviewed, including development plan. It was noted that many of the workings are within 37 metres above a previous inseam working which, due to the nature of support, could not be guaranteed to be open for inspection. Some proposed workings could

[8] It is a handwritten note which probably found at the manager office.

> approach from downgrade towards workings at a higher level. **The mine is wet and it is possible some of the old workings could contain water, although most are driven on the water level and are self-draining.** The principles of The Mines (Precautions Against Inrushes) Regulations 1979 were explained. It was advised that since much of the inseam working is carried out within 37 metres of old workings, carried out from this mine, a generic PUWER scheme should be applied, which requires advance and flank boreholes to be drilled when approaching previous workings which could not be inspected. The manager agreed to consult his surveyor and submit a suitable scheme. (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 25, author's emphasis).

This may be evaluated as a possible explanation for the water issue. Furthermore, the professional, Adam Anthony (geologist), shared findings that relied on a laser survey of the area, including the main drift and the northern end of the old Top Road about the volume of water and its origin. The complexity of the water problem is explained in the following extract from the court hearing:

> The potential area was 3,786m2, that is also on that page. And in his evidence, Mr Anthony described that as an accurate calculation. However, he accepted unreservedly that the accuracy of the calculation did depend upon the accuracy of the water line on the mine plan.
>
> The next calculation which Mr Anthony undertook was the area covered by the water which had come through the working stall. Mr Anthony accepted that this calculation would be less accurate because, of course, as I've reminded you, this calculation was dependent, to some extent, upon eyewitness accounts of the extent of the water which had come through the stall.
>
> Mr Anthony calculated that the area covered by the water was 3,154 m2.
>
> This page was produced to demonstrate where the water line in the mine might be, upon the assumption that Mr Thomas's evidence was accurate as to the route which he took through the Central Workings when inspecting air routes.
>
> What Mr Anthony's evidence does not solve is the issue of whether the water which burst through the stall was lying in an area to the north of the stall for any significant length of time before it happened. What it does tend to show, however, is that immediately before the inrush occurred there was, at least, a substantial volume of water lying behind the breach point. Now, when you actually analyse what various people have said, the only person who actually gave evidence along the lines of:
>
> 'I'm not sure that the water came from behind the breach point' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 26–27).

Mr Anthony's statement agreed with Mr Thomas' finding, despite some of his (Mr Thomas) findings not relying on precise results. Although many uncertainties led to conflicts in court, the CPS tried to convince the jury of Mr Fyfield's guilt.

*Table 7-2 Actors' Testimonies*

| Actors' findings | The place from which the water came | Where/when the volume of water accumulated |
|---|---|---|
| ***Mr Foster*** | The water that had entered the inrush stall had come from the area immediately behind the breach point. | The mine is wet, and it is possible some of the old workings could contain water, although most were driven to the water level and were self-draining. |
| ***Adam Anthony*** | The area covered by the water after the inrush was slightly less than the potential area in which the water could have been lying in the central workings. | 'Immediately before the inrush occurred, there was at least a substantial volume of water lying behind the breach point. I'm not sure that the water came from behind the breach point'. |
| ***The CPS*** | A large body of water was lying in the old central workings to the north of the breach point by the time the explosives were used on the morning of the 15th of September. | 'A substantial amount of water lying in the southern end of the Old Central Workings for a significant period of time before September 2011'. |
| ***The Rescue Team (Peter Jones and Brian Thomas)*** | There **(on the Top Road)** was a considerable volume of water beginning at a point approximately 30 to 40 metres from the junction of the main drift with H1. | Judge: If Mr Thomas is accurate, he was prevented from going down the length of the Top Road by the presence of water. **Where did it come from? It wasn't there, clearly, when Mr Fyfield escaped.** |
| ***Defence*** | in the Top Road. | 'The water was not lying there [, so] the flood happened because of heavily rainfall. The evidence of the water marks in the Top Road. That there was a substantial volume of water at or about the point of the water marks, hours after the inrush occurred'. |
| ***Dr Cobb*** | **(i)** If some of the pillars had collapsed, if the south-east workings contained an accumulation of water, which everyone, in this case, appears to accept that it did, then that water could have been dispersed into the central workings. **(ii)** There had been a build-up of debris within some location in the mine, which had acted as a dam to the flow of water, but this dam had burst some hours before the inrush occurred. | **(iii)** Water permeated the sandstone roof and had been released at a point to the north of the breach point but then flowed down to accumulate immediately behind the breach point. (iv) **Void migration**. The void is then transmitted, by geological processes, to a point above the level of the inrush stall. That would create the means by which water could flow to the area behind the stall.[9] |

The CPS supported their claims with Dr Pritchard's statements about the accuracy of Mr Rees's claim that Mr Fyfield knew about the existence of the water issue before the accident (see the detailed discussion on R v MNS Mining Ltd and Malcolm Fyfield, 2014, pp. 10–12). Further, the efforts of the CPS can be observed in many of the judge's statements:

> What Dr Cobb does not accept is that this body of water must have been lying in that position between 11.30 am and 1 pm the day before and before dealing with his evidence about that,

[9] The statements placed in this table was quoted from court hearing (see, *R v MNS Mining Ltd and Malcolm Fyfield, 2014, p. 16, 17, 24, 25, 27, 28, 29, 31, 32)*

> let me remind you to put it in [the] context of the various sources of evidence relied upon by the Prosecution to prove that the water must have been lying behind the breach point for a significant period of time.
>
> The defence team was against these arguments by asserting that the water was not lying there; the flood happened because of 'heavily rainfall' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 28).

Dr Cobb's extended explanation was presented in court because it was thought to contribute to the conflict related to the water issue. The table above summarises the points made by different actors about the water issue, which allows us to consider the complicated decision-making process and the various opinions.

As the various statements highlight, most predictions and findings rely on possibilities. There were also other uncertainties in terms of providing enough clear evidence. For instance, the explanation provided by Dr Cobb contributed to the company's defence and the CPS's arguments because he stated more than one possible scenario. However, his findings supported far more of the defence team's points than the CPS's claims. Furthermore, this discourse refers to a lack of investigation in the mining area, and non-investigated areas may have played a critical role in considering whether Mr Fyfield and the company were (ir)responsible with regard to this incident.

### 7.4.2 The judge's approach

The judge took an objective position during the court case due to the last court hearing (Hearing date is 19 June 2014). The judge generally contributes to a case by summarising critical points for the jury's consideration, such as witnesses' and professionals' statements. However, this cannot be considered a positive contribution to securing justice.

Some of the relevant parts of the discussion highlight the judge's approach to the conflict between Mr Fyfield and Mr Rees (This discussion occupies more than four pages at the court hearing):

> Judge: And so, you are going to have to resolve that conflict. (…) That is for you and you alone to determine. No doubt you will wish to consider your assessment of Mr Rees in line with what occurred on the day when he went to the mine, that is the day of the incident, because you'll remember that you heard some evidence about Mr Rees turning up at the mine on that day with his files and, at one stage, his files were left in the mine office when he went off somewhere and he came back and found the Mines Inspectors looking through his files and he didn't like it, and he was, according to Ms Evans, very defensive about it. So, again, in making your assessment of Mr Rees, you will need to take that into account (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 8).

The judge generally left the jury alone to make decisions about contradictory statements such as these. However, in this instance, the judge's contribution was to highlight those contradictions.

The judge's approach can be analysed as a sign of the importance of being objective and critical. It is important that a judge is unbiased. However, it is difficult to say whether, in this case, this approach was helpful in terms of the jury reaching its verdict. Additionally, some discourses indicate that it was challenging for the jury to decide whose statements were accurate. Some parts of the judge's summary of the case are presented below to indicate the judge's approach and the jury's challenging decision-making process:

> Ultimately, you may wish to ponder how much, in truth, on Mr Forster's evidence about his actual investigation and the results of that investigation, is actually challenged. It is a matter for you and you alone, members of the jury, but you may feel that the crucial issue in relation to Mr Forster's role is not his impartiality or lack of it but rather whether the extent of his investigation was sufficient, but that is a matter entirely for you to determine.
>
> **What is important is that neither** Mr Forster nor Mr Godamky investigated any significant distance to the east of the breach point. Mr Godamky did say, in answer to Ms Evans, that he went a little distance to the east of the breach point and because he had done that, he could tell that there was an air route in that location because he could either feel or hear air. Anyway, for whatever reason, there was no further investigation by either man of any area to the east of the breach point (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, pp. 23–24, author's emphasis).

The brief but contradictory points that were discussed in court are essential to understand the verdicts given. The following section focuses on the discrepancies between the defence and Crown arguments.

### 7.4.3 The punishment

The roles of agencies, the background of the case and the court investigation addressed factors and conditions that led to a not guilty verdict. In this section, I outlined primary contradictions in the case and notable points highlighted by the judge, which were presented for the jury's final consideration.

Although Mr Fyfield explained how he found a way out, as he had used the same route a few times previously, the CPS claimed he did not rely upon the facts; instead, they said it was luck (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 15). In addition, according to Mr Thomas,[10] who was a member of the rescue team, a large quantity of water spread to the mine from the 'old Top Road' because he observed water in that area the previous day (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 18).

After summarising the evidence and the professionals' thoughts, the judge drew the jury's attention to two particular issues: (i) where the water came from and whether Mr Fyfield's

[10] He was on the old Top Road on the 15th of September, the day after the accident.

statement was accurate and (ii) 'whether or not it was likely that the water was already lying in the area to the north of the breach point on the day before the incident and that relates to the drilling through', as this was thought to be critical to the decision-making process. The judge indicated, 'You've heard the rival contentions about that, put at length in closing speeches. You must make up your mind about it' (*R v MNS Mining Ltd and Malcolm Fyfield*, 2014, p. 34).

The judge's instructions and witnesses' and professionals' statements led to confusion over who was responsible for the wrongdoing and the jurors struggled to make the right decision.

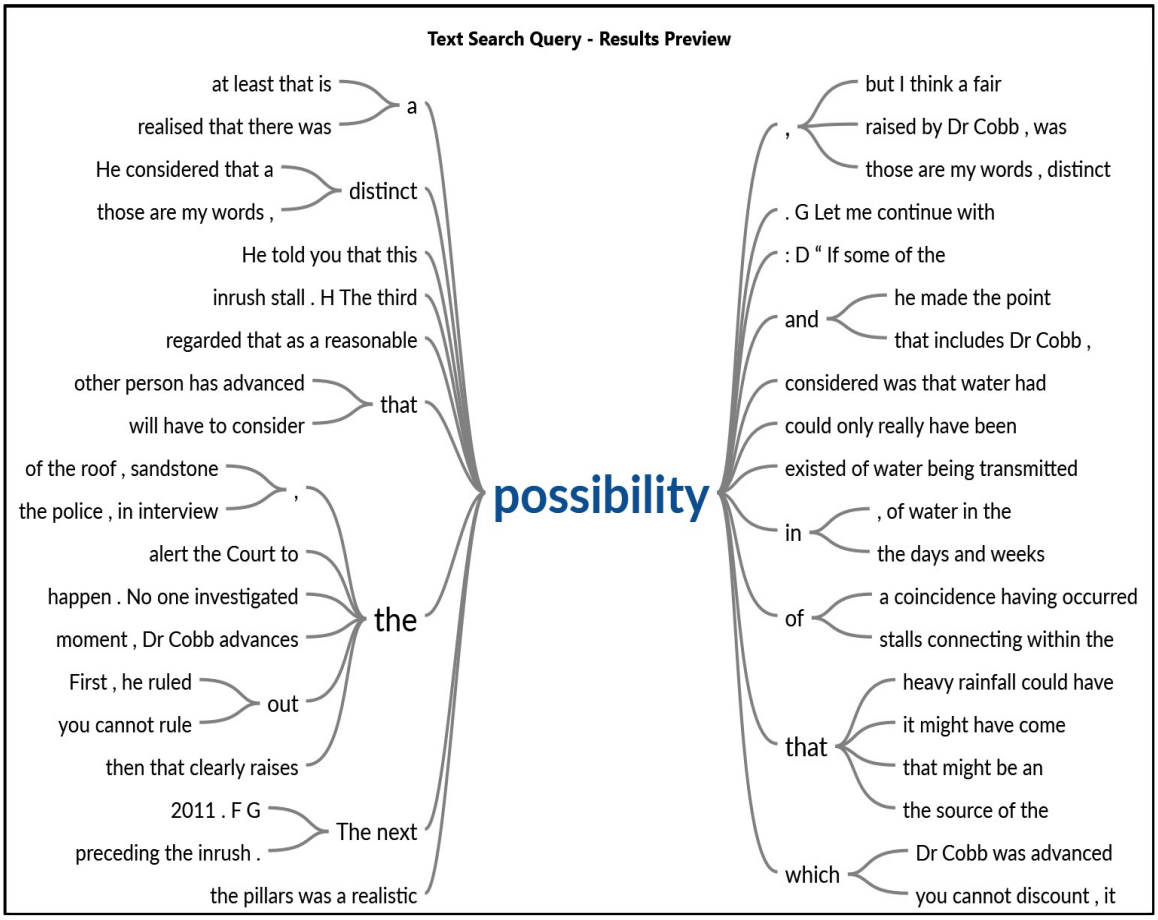



*Figure 7-3 The places of the word 'possibility' found in the court transcription*

I searched the word 'possibility' in the court hearing transcription, and I found that it was used more than 20 times in court. Indeed, most of these instances were in critical parts of the court discussion, such as while discussing the reason for the flooding. This emphasises the uncertainties that made the decision process difficult for the jurors, who struggled to make an accurate and lawful decision.

At the end of the trial, the judge read a paper consisting of a series of questions, believing it would assist the decision-making process. There were many questions, but they related to each other. Mr Popat (the barrister) mentioned this similarity. Question one was perhaps the most important, and the company's defence team drew the court's attention to it.

The questions posed to the jury were made to clarify several particular issues: (i) the accuracy of Mr Fyfield's statements, (ii) whether the CPS had convinced the jury about Mr Fyfield's irresponsibility, (iii) Mr Fyfield's role in the accident that led to the deaths, (iv) if My Fyfield did play a role, whether it could be considered gross negligence and (v) depending on the jury's verdict, whether MNS Mining Ltd was guilty of corporate manslaughter.

The analysis of court prosecution acknowledges that police agencies paid close attention to whether Mr Fyfield made wrongful actions or not instead of a whole organisational failure. One of the remarkable points is that the senior managers (Gerald Ward or Maria Nora Seage) of the MNS Mining and their role in the deaths were not placed in the court. Tombs (2018, p.498) highlights this issue that 'Of interest, this was the first time a non-director's actions were the basis for a corporate manslaughter charge, though there was no judicial consideration of what amounts to 'senior management under the Act'.

The judge highlighted that the act and negligence should be obvious and that this was severe enough for the jury to return corporate manslaughter verdicts (Dobson, 2014; *R v MNS Mining Ltd and Malcolm Fyfield*, 2014). Due to the conflicts that arose from the collected evidence, the jury returned not guilty verdicts. As it can be understood over questions (which Jury consider end of the court hearing), the company and owners were not punished for individual culpability. This issue undermines the structure and effectiveness of the CMCH Act. As discussed in the literature review, this act made it impossible to punish owners and people who benefit from the company (Hébert, Bittle and Tombs, 2019). Further, Braithwaite's (1984) proposal that corporations can be charged in court instead of individuals must be reconsidered.

## 7.5 Conclusion

The prosecution process took three years, even though the jury only took two hours to decide. Although the judge thought Mr Fyfield had made a serious mistake, it was not enough to charge the company with corporate manslaughter, according to the judge (Stone, 2014). The crown prosecution and court discussion show that 'senior management test' did not help to secure justice. A likely explanation is that agencies focused on individual rather than organisational failure.

The court transcript, news reports and the HSE's statements revealed that the company and Mr Fyfield failed in two areas:

(i) The water issue was known prior to the incident but was not seriously considered.

(ii) It is high likely that the PUWER application was not properly completed.

It shows that each case is not perceived as a severe crime, while corporate manslaughter cases are perceived as more serious. I observed this situation in the fieldwork. Considering this issue, HSE P1 stated:

> In rare cases where there is evidence of **management failings so serious as to potentially amount to corporate manslaughter,** we would notify the police at the earliest opportunity (whilst the investigation is ongoing) and seek to pass primacy back to the police. If the police accepted primacy, we would expect to remain involved in the investigation and work alongside the police to gather evidence. This is because the offence of corporate manslaughter requires a 'gross breach of a relevant duty', which, in practice, is normally a health-and-safety duty under the Health and Safety at Work etc Act 1974 (HSWA). HSE investigators have the skills to investigate health-and-safety breaches, therefore it makes sense that the police should work alongside the HSE in gathering evidence of breaches of health and safety which may be used to support a charge of corporate manslaughter. In such cases, the police/CPS often rely upon the HSE to provide expert evidence (06/01/2021, author's emphasis).

Another important finding related to the investigation and punishment process is that the case was complicated by the collection of evidence and experts' opinions presented to the court and the witnesses. This case indicates that some negligence was not covered by corporate manslaughter law. As discussed in the introductory chapter, there is still a need to discuss the implementation of laws and the characteristics of criminals, including which kinds of legal actions should cover negligence (Simpson, 2013). The level and seriousness of negligence in relation to accidental death decisions and the violation of health and safety law will be discussed in Chapter 8: Illustrative Vignettes.

In this case, the CPS played a remarkable role. The police agency (the CPS) gave a relatively positive performance to secure justice by sending the case to court under the CMCH Act and proving the manager's and company's negligence considering the evidence. The CPS's primary arguments in court were that there was knowledge of a possible water leak, the water accumulated in the southern end of the old central workings, a PUWER application was ignored and not submitted, and required measures were not taken.

The fundamental actors for the HSE (Mr Rees (local authority), Mr Forster and Mr Yoxhall) undertook a series of inspections in the mining area before and after the incident. Taken together, the HSE's and local authorities' roles in the prosecution and punishment processes show the importance of non-police agencies' contribution to (not) securing justice. This also highlights the differences between safety crime policing and policing of other crimes, which was discussed in the literature review (see Chapter 3 and Tombs and Whyte, 2007). Furthermore, the role and approach of non-police agencies will be analysed using various vignettes in Chapter 8: Illustrative Vignettes.

The court had the most critical role in not securing justice, considering the verdict of not guilty. On the one hand, the judge did not take a pivotal role, even though he summarised and clarified critical points for the jury. On the other hand, the jury was a game-changing element, as they declared the innocence of the company.

Another issue is how agencies applied the new Act in this case; (i) even though one of the senior managers was not Mr Fyfield, the crown perceived Mr Fyfield as a 'controlling officer'(it may derive from his testimony, 'a hands-on manager'-see p.136) (ii) the court prosecution overwhelmingly focused on Mr Fyfield's testimony and acts rather than organisation failure though the new Act does not allow personal liability (iii) the level of negligence was not enough to punish the company for jury. This issue will be discussed further in Chapter 9.

The findings of this case study help to indicate factors, such as unsatisfactory and questionable evidence, that underpin not guilty decisions for corporate manslaughter. The factors and conditions led to giving a not guilty decision will be discussed in chapter 9. The next chapter (Chapter 8: Illustrative Vignettes) will provide insight into different types of unpunished cases, such as accidental deaths.

# Chapter 8 Illustrative Vignettes and Their Features

## 8.1 Introduction

In this chapter, I scrutinise the criminal justice system's responses to workplace deaths by exploring the narratives and patterns of WRD investigation and punishment processes through crime vignettes that differ from the two case studies. The case studies (Chapters 6 and 7) analysed guilty and not-guilty decisions of corporate manslaughter while the vignettes analysed other investigation results.

As discussed in Chapters 1 and 3, the treatment of work-related corporate offending has seemed problematic (Michalowski, 2015; Ruggiero, 2015; Pearce and Tombs, 1998). This concerning picture derives from government policies on corporate and safety crimes (Tombs and Whyte, 2007) and ongoing theoretical discussions in criminology (Levi and Lord, 2017; Simpson, 2013). In this chapter, I empirically interrogate the prosecution and punishment processes for WRDs considering police and non-police agencies' approaches to WRDs and the factors that affect the evaluation of a case as a crime. In this way, this chapter will help to answer the research questions (see Chapter 1).

As mentioned in the introductory chapter, the conceptualisation of WRDs in terms of the punishment given and police and non-police agencies' approaches is fundamental to this study. Therefore, I focus on four primary investigation and punishment result types of WRDs: 1) cases investigated under health and safety regulations accidental death verdicts (punished and unpunished instances considering safety crimes); 2) gross negligence manslaughter (but not corporate manslaughter); 3); 'no information' and 'no further information on court process' cases and 4) accidental deaths (different inquest processes). These categories were identified and defined in Chapter 5. In this chapter, I will conduct an in-depth analysis of these categories using various official documents, mass and local media news reports and more. It will provide critical insights into the characteristics of different types of results related to investigation and punishment processes. The findings will contribute to reaching a conclusion, along with findings from other chapters (Chapters 6 and 7). Other chapters have not provided findings related to non-investigated WRDs, WRDs that resulted from a safety crime, unpunished cases (which differ from the Case 2 -instance of not guilty decision of corporate manslaughter; see Chapter 7) and gross negligence manslaughter. I believe this chapter helps to explain instances of these types.

In this chapter, vignettes are used as individual examples that can be observed. Kesselring (2020) proposed a careful selection process to use vignettes for analysis (see Chapter 4). Vignettes were chosen carefully using certain rationales:

1) The vignettes were chosen from the four types of prosecution results gleaned from Chapter 5.

2) The vignettes are explanatory and reflect the patterns of four different result types.

3) The vignettes all took place between 2008 and 2016, and their court processes have been completed.

The same number of vignettes were not selected in each category because: some types of verdicts occupy much more space within the criminal justice system than others - for instance, punished and unpunished cases under health and safety regulations comprised majority of all investigated cases while gross negligence manslaughter decisions made up less than 2 per cent; therefore, some categories need much more attention than others.

To the best of my knowledge, a study that analyses various types of WRDs' prosecution and punishment processes by focusing on 14 vignettes has not been conducted or reported before in the criminology literature. I believe the findings of this chapter will contribute to the literature on safety crimes by indicating relevant factors and how the roles and approaches of police and non-police agencies influence final decisions.

## 8.2 Vignettes under the health and safety regulations

Many cases have involved punishments under the HSW Act rather than the CMCH Act. Additionally, many cases went unpunished. Thus, a brief analysis of five punished vignettes and two unpunished vignettes provides helpful insights into the research questions.

### 8.2.1 Vignette 1: Wood Flour Mills

The deaths of Derek Moore, Dorothy Bailey, Derek Barks and Jason Shingler highlight specific characteristics that help us understand why health and safety crime verdicts are delivered instead of corporate manslaughter verdicts. An explosion led to the accident that resulted in these four workers' deaths at Wood Flour Mills in Bosley on the 17th of July 2015. Two companies, Boden and Davies Limited and Wood Treatment Limited, were involved in the case. George Boden, Charles Boden and Andrew Lowden were the actors responsible for wrongdoing on behalf of these companies (*R v Wood Treatment Limited and George Boden*, 2021). This example indicates

that it was not difficult for police agencies to find actors responsible for wrongdoing, even though there were two companies and more than four owners and managers.

The prosecution and punishment processes in this example are critical because they indicate how satisfactory and clear evidence has a substantial place in the final decision, compared to how justice is administered and the role of police agencies. This is evident in the court discussion (*R v Wood Treatment Limited and George Boden*, 2021, p.2):

> For reasons which are set out fully in my ruling given on a defence submission of no case to answer, and in the Court of Appeal decision upholding that ruling, the **Crown's case on the evidence was insufficient to support the manslaughter charges. There was no option but to direct the Jury to return not guilty verdicts on those charges** (author's emphasis).

This vignette has similar characteristics to MNS Mining case (for further details, see Chapter 7) because the manager and the companies were found not guilty of corporate manslaughter and gross negligence manslaughter due to insufficient evidence. However, this vignette also tells a different narrative to Case Study 2 because the managers and companies were punished under health and safety laws. In the MNS Mining case, the court did not impose sentences or fines on the manager or company. Wood Treatment Ltd was charged with safety crimes, and the owner, George Boden, was sentenced to nine months in jail, but the sentence was suspended for 18 months (Health and Safety Executive, 2021b). This highlights the pattern of favouring safety convictions over corporate manslaughter convictions and raises a question about the circumstances that influenced the police agencies' decision to punish these companies and managers in a different way than they did in the MNS Mining case. One possible answer is revealed in the court discussion:

> The charge against the company was brought under Sections 2 and 33 of the Health and Safety at Work (etc.) Act 1974. WTL [Wood Treatment Ltd] pleaded guilty to this offence on first arraignment 2 months before the commencement of trial, **but on a basis under which the company accepted some failings over the six-year period, but not such as to cause the explosion resulting in the deaths on 17 July 2015.**
>
> **(…) There are two important matters for the court to bear in mind in making the necessary findings: first, I must be satisfied of any matter to the criminal standard, that is to say, I must be sure. Second, I am bound by, and must stay true to, the acquittals directed in respect of the manslaughter charges, and to the basis of those acquittals, which is that the Crown did not succeed in establishing the necessary causative link, to the criminal standard, between negligence on the part of WTL and GB and the explosion which led to the deaths. In short, I cannot sentence either defendant on the basis that their action or inaction caused the deaths of the four employees on 17 July 2015** (*R v Wood Treatment Limited and George Boden*, 2021, p.3, author's emphasis).

The investigation and court proceedings for this case took almost four years. On the last day of the court case, Wood Treatment Ltd and George Boden were found not guilty of gross negligence

manslaughter and corporate manslaughter. According to court documents, the judge asserted that the CPS had not convinced the jury to impose a sentence.

Many examples of wrongdoing, such as an unimplemented cleaning policy and small explosions (*R v Wood Treatment Limited and George Boden*, 2021, p. 6), were noted by agencies and witnesses in court. It was even noted in court that 'Incidents of smouldering in the pelleting machines happened regularly, up to and including on the day before the explosion' (*R v Wood Treatment Limited and George Boden*, 2021, p. 6). Moreover, an employee described the mill as a 'ticking bomb; and this worry was shared with managers, but the answer was "We're not making any profits, we need to make money"' (BBC, 2021a). The judge mentioned, ' All parties accept that the seriousness of harm, under the guideline, was at Level A' (*R v Wood Treatment Limited and George Boden*, 2021, p. 7). Another piece of evidence was presented by a fire officer, who stated, 'There was a quantity of material which was able to explode in this way – without which there would have been no explosion, there would not have been four tragic deaths, and others would not have been seriously injured' (BBC, 2021a). These records show that the company had a poor safety record and committed various violations. However, these actions were not enough for companies to be punished for corporate manslaughter.

The explosion caused severe damage to the accident scene, and this aggravated the investigation and evidence collection process (BBC, 2021a; ITV, 2021). This may have led to the not guilty verdicts, as the judge stated that 'there was not enough evidence to prove (…) gross negligence'. Court documents reveal that the court was not satisfied with the argument that failures and a poor safety record caused the explosion. However, the police were not satisfied with the final decision, as one detective articulated (ITV, 2021):

> We understand that this will not be what the families had hoped for and that it will not take away from the devastating loss they feel. We know that this has been an extremely difficult time for everyone involved, and we are continuing to support the families as they come to terms with the outcome.

News reports suggest that police and non-police agencies collaborated on this complicated case (Avery, 2021; ITV, 2021; BBC, 2021a). The CPS and police intended to charge the company with corporate manslaughter; in addition, the HSE presented evidence about the company in court (BBC, 2021a; ITV, 2021).

This vignette provides another example of the court paying attention to a company's financial situation, as a fine was imposed, and the judge applied 'a reduction 1/3 for a guilty plea' (*R v Wood Treatment Limited and George Boden*, 2021, p. 9). Subsequently, the judge's approach can be defined as lenient, compared to convicted corporate manslaughter cases:

> **I do not believe that he *(George Boden*) deliberately disregarded**, wholesale, the law in relation to health and safety, but I am satisfied that he recklessly ignored what the law required the company to do, prioritising spending in other directions. (…) **There had been, and continued to be, some very serious breaches of health and safety requirements, but I am not satisfied that they amounted to a flagrant disregard of the law.** GB was a totally inadequate MD, incapable, as the evidence showed, of understanding or insisting upon the introduction of necessary safety measures; the task was simply beyond him (author's emphasis).

These discourses illustrate a significance point that the court's approach, proof of a poor safety record and several forms of negligence are the main factors influencing the final decision. This lenient approach can be observed in the suspension of prison sentences and reduction of fines. The amount of the fine (in this case) is relatively less than the punishment given in the case of Nikolai Valkov. This vignette also supports the criticism raised in the literature regarding the seriousness of corporate manslaughter and how governments take a lenient approach to corporate manslaughter (for further information, see the discussion in Chapter 3).

### 8.2.2 Vignette 2: The deaths of Adam Taylor, Peter Johnson, Tomas Hazelton and Daniel Hazelton

Adam Taylor, Peter Johnson, Tomas Hazelton and Daniel Hazelton died due to a 13-tonne steel structure collapsing in Great Yarmouth in January 2011. Three companies, Claxton Engineering Services Ltd, Encompass Project Management Ltd and Hazegood Construction Ltd, were involved in this case.

The importance of this vignette relates to the punishment imposed because the companies were not charged under the CMCH Act. The police and the CPS investigated the case for more than a year (14 months), but then the CPS decided that there were no grounds for charging the companies with manslaughter (Safety and Health Practitioner, 2014). Even though the police were not satisfied with this result, it did not change the decision (Safety and Health Practitioner, 2014).

The HSE articulated the failures in court:

> Access to the trench was via a ladder, some of the side wall had collapsed, and water needed to be pumped out of it. The area was 'marsh land' and had needed piling work earlier in the build, he added. The site was deemed unsafe for investigation after the deaths due to unsupported side walls, and further piling work was needed.
>
> The reason the structure collapsed was that it had no bracing; there were no diagonals anywhere in it, so it was effectively like a stack of cards with no diagonal cards. The lack of bracing was due to the firms' failures to plan the work properly and think through the risks. This was a major project,' she said, 'and these companies were not capable or competent to deal with work of that nature (HSB, 2017; Safety and Health Practitioner, 2014).

The court discussion, the HSE's statements and the punishments imposed indicate that the companies and certain individuals played a role in the four workers' deaths. However, police agencies, especially the CPS, did not consider the failures serious enough to evaluate the case under the CMCH Act. These types of vignettes show that police agencies, mainly the CPS, tend to apply the health and safety act rather than the CMCH Act.

The critical point here is that agencies' evaluation policies change from case to case, even when companies commit similar forms of serious negligence. For instance, in the case of Nikolai Valkov, the negligence demonstrated (the unsafe working conditions that were proven in court) is similar to this case, but the final decision was the opposite. There were also other similarities, such as the presence of a contractor company and more than three actors. The only apparent difference is that one of the companies can be defined as a medium-sized company.

This vignette illustrates applied punishments. In total, the court fined the company £700,000, jailed one of its directors, David Groucott, and ordered him to carry out 200 hours of community service. However, the prison sentence was suspended for two years.

### 8.2.3 Vignette 3: The death of Paul Williamson

Another instance of a safety crime decision is provided by the case of Paul Williamson, who was killed in 2014. Manchester Crown Court jailed the director (Kenneth Thelwall) of Thorn Warehousing Limited for 12 months for safety violation, and the company was fined £166,000 (Barett, 2016; Health and Safety Executive, 2014). Even though the company was accused of corporate manslaughter in 2012 and admitted health and safety failings (Cheshire Live, 2016), the company was not found guilty of corporate manslaughter. This was possibly because of the CPS's advice in these types of cases, as previously mentioned. This case also indicates that a worst safety record (another worker of this manager died before this case) is not enough (is not an influential factor) to charge a company for gross negligence manslaughter or corporate manslaughter.

The negligence of the company identified in court was not providing essential training on equipment such as the ramps and lorry (Cheshire Live, 2016).

Criminal justice agencies do not always respond to safety crimes in the same way. The courts can give guilty verdicts sometime after deeming accidental death verdicts. This can be observed in certain cases that occurred during the period 2008–2016. These types of cases highlight the same characteristics, so these relevant cases help explain the criminal justice system's treatment of WRDs from a different perspective.

### 8.2.4 Vignettes 4: The death of Douglas Skinner

In some cases, the coroner court jury delivered a verdict of accidental death, but the companies involved were charged later. This can be observed in the death of Douglas Skinner. In this case, the jury asserted a 'unanimous conclusion of accidental death' in February 2017 (Noble, 2017). However, Ipswich Crown Court fined the company (SPR Trailer Services Limited) £120,000 over violations of health and safety acts on the 18th of January 2018 (Health and Safety Executive, 2018). Two important characteristics can be determined from this. First, although the jury returned an accidental death verdict, the HSE continued to investigate the case. Second, when new evidence was collected or reported, it prompted the launch of a new prosecution process.

The HSE's contribution to justice is evident in interviews with its staff. For instance, a member of the HSE (P1) stated:

> So, we're always with one eye on, obviously, the need to secure justice and make sure that the charge reflects the wrongdoing that occurred, but also the need to make sure that we don't spend a disproportionate amount of resources pursuing something that doesn't have a realistic chance of coming to [fruition]. So, these are the decisions that are made, from the start of the investigation right to the very end, and in some cases, or perhaps in many cases.
>
> (…) so, we often, in most cases, wait until the inquest has concluded. Because before we would consider whether and what charges to bring because of that very reason that something could come out at the inquest. Because the coroner is there, obviously, the coroner has a different objective to us. The coroner is looking to find out how the person died, essentially that is their remit. Not whose fault, but, as you can see, it's a courtroom where evidence comes out. So, we, from time to time, we'll find something new that comes out through that process that is material to our decision of what failings we should bring charges for (14/05/2021).

Similar cases emphasise decisions that have changed in due course. One of these instances is outlined to enhance the reliability of this argument.

### 8.2.5 Vignette 5: The death of Simon Hogg

The death of Simon Hogg is another illustrative example of the kinds of cases that occurred in 2015–2016. Simon Hogg died on the 12th of December 2015 while his colleagues were turning on a trommel in Aycliffe. Even though some acts of negligence were stated in court, the jury at Durham Crown Court did not punish anybody and returned an accidental death verdict in January 2019 (BBC, 2019b). One of the HSE inspectors stated after the court case was concluded that 'Investigations are continuing by the HSE' (BBC, 2019b).

This incident should be a warning to businesses about the risks associated with close machinery interventions and their duty to ensure that robust, effective power isolation systems and procedures are in place.

However, after two years, the court found Stonegrave Aggregates Limited guilty and imposed a £110,000 fine (HSE, 2021c), a one-year community order and a six-month prison sentence (suspended for one year) (BBC, 2021b). This vignette is an example of the HSE's contribution to securing justice as it made considerable effort to ensure justice, even after the first court, case was complete.

### 8.2.6 Vignette 6: The death of Kevin Dorman (Not Guilty)

Kevin Dorman died while working at Clinton Devon Farm Partnership on the 19th of May 2014. The main circumstance that led to his fatal injury was his trailer's brakes. In the first session of the case at Exeter Crown Court, it was argued that 'Kevin Dorman's death was "totally unnecessary" and caused by "criminal negligence" in the "dreadfully poor standard" of maintenance of the brakes on the trailer' (Court Reporter, 2019).

In January 2019, the prosecution alleged that Colaton Raleigh and George Perrott were guilty of acts of manslaughter (Greaves, 2019). However, in February 2019, a jury found them not guilty of manslaughter and asserted that they were not in violation of health and safety acts. Although the jury visited the area where the incident occurred and investigated the trailer, they could not find sufficient or clear evidence to return a guilty verdict (Farmers Weekly, 2019). Agencies focused on technical failures and whether the brakes were checked prior to the accident.

Published news, media and legal records make it difficult to assess whether the HSE and police played critical roles in arriving at the result of this case. In this instance, it seems that the jury had a crucial role over other agencies. Furthermore, difficulties in finding *satisfactory evidence* were a primary factor in returning the not guilty decision. The unsuccessful prosecution of this workplace death led to individuals going unpunished. As Tombs and Whyte (2007, p. 103) claim:

> It is rarely the case that the failure to prosecute is merely down to insufficient evidence. It is the under-investigation of safety crimes and the lack of resources dedicated to inspection that are the key factors in keeping detection rates low.

I will return to discuss this argument in the conclusion; however, it is worth mentioning here that Kevin Dorman's death is a 'rare' case due to agencies' consideration.

### 8.2.7 Vignette 7: The death of Neal Edmonds (an instance of Crown Censure-Unpunished)

An analysis of media reports shows that a Crown censure was imposed in a case on 11th of June 2014. This verdict helps to explain two important points: the realm of applied justice regarding corporate offences and the response of governmental agencies to WRDs.

Neal Edmonds was serving with the Royal Navy. He died while trying to solve a technical problem related to a lift on a warship on the 11th of June 2014 (BBC, 2015e). Various health and safety rules were broken (O'Leary and Elmes, 2018). The police investigation showed that Edmonds had alcohol in his system (more than three times the legal driving limit) before the incident (BBC, 2015e).

According to the HSE, one of the responsible agencies, in this case, was the Ministry of Defence. However, the MoD did not provide a safe working environment for the engineering technician (O'Leary and Elmes, 2018). Jane Lassey, the HSE's deputy director of field operations, stated:

> The risks arising from maintenance operations are well known, and suitable measures required to reduce these risks are understood. Like any employer, the MoD [Ministry of Defence] has a responsibility to reduce dangers to its personnel as far as they properly can, and in this case, they failed Neal Edmonds (O'Leary and Elmes, 2018).

The court indicated the failure of those responsible for checking safety procedures (O'Leary and Elmes, 2018). A Crown censure was imposed, and the coroner warned the Ministry of Defence that a safe working environment should be provided. However, the MoD and the Royal Navy were not prosecuted or charged under the CMCH Act or health and safety regulation. This is an important point since one of the aims of this act was to ensure that governmental bodies could be prosecuted and fined (see Chapter 2). In this case, criminal justice agencies did not apply the CMCH Act. According to their records, the HSE imposed 22 Crown censure decisions between 2009 and 2021 (Health and Safety Executive, 2022). This finding suggests that when governmental bodies are involved in a case, the police and non-police agencies do not tend to consider the case to be corporate manslaughter or another safety crime. Accordingly, Crown censure decisions can be understood as a lenient approach, in which regulations and policy rely on negotiation, rather than a severe approach to safety crimes. Furthermore, Crown censure decisions can be accepted as a factor in the low number of convicted corporate manslaughter cases.

## 8.3 Gross negligence manslaughter vignette

The gross negligence manslaughter charge is another confusing point that can be evaluated as a factor in the low number of convicted corporate manslaughter cases. The CPS plays a more important role than other agencies in WRDs of these types, and it recommends gross negligence

manslaughter rather than corporate manslaughter in some cases. This issue is explained by the CPS as follows:

> The evidence may indicate that the offence was due to the gross failings of identifiable directors or managers. In such a case, it may be more appropriate to charge the responsible individual(s) with gross negligence manslaughter rather than the corporate offence. This situation is more likely to arise in the case of small and micro-companies, where the whole or very largest part of the failing is the responsibility of one person whose personal activity represents a large part of the company's undertaking. In that situation, the justice of the case can best be met by the prosecution of the individual(s) rather than of the company for the manslaughter offence. It may be appropriate in such circumstances to charge the company with an offence under the Health and Safety at Work etc. Act 1974 (HSWA) (Crown Prosecution Service, 2018).

Statistics indicate that these kinds of cases occur almost every year.

### 8.3.1 Vignette 1: The death of Mason Beau Jennings

The courts delivered convictions for gross negligence manslaughter in two cases between 2014 and 2015. The death of Mason Beau Jennings is a relevant example that highlights why sentences were imposed for gross negligence manslaughter instead of corporate manslaughter. Mason Beau Jennings was only 17 years old when he was killed on the 4th of December 2014. He worked as a cleaner at the Coach House in Devon when he fell from a ladder due to an unsafe working environment (ITV, 2016). Exeter Crown Court imposed a five-year prison sentence on his boss, Colin Jeffery, who was found guilty of manslaughter by gross negligence. It is likely that the police's statement in court was an important factor in this verdict. The police stated that Jeffery had a 'total disregard for the safety of his employees. Most of the workers were young men who were vulnerable to the risks of dangerous work by virtue of their youth, inexperience, and inability to appreciate risk' (BBC, 2016b). Additionally, Inspector Steve Davies stated that Jeffery 'completely failed to consider or implement even the most basic of safety measures. His working practices were inevitably going to lead to the serious injury and death of one of his employees at some point in time' (BBC, 2016b).

Judge Graham Cottle made a statement directly to the company owner, asserting that 'You exposed Beau to the very obvious risk of death by requiring him to carry out that work from a ladder. Your attitude throughout was arrogant, cavalier and utterly reckless' (ITV, 2016).

The question arises here as to why the company was not charged with corporate manslaughter. The most probable reason is that the CPS recommended gross negligence manslaughter sentences instead of corporate manslaughter in some cases, which suggests that the CPS's role and policy are influential factors in delivering gross negligence decisions instead of verdicts of corporate manslaughter.

## 8.4 'No Information' and 'No Further Information on court processes' vignettes

In this section, I examine some illustrative 'no information' and 'no further information' cases to outline the reasons and rationales underpinning why these cases were not described as crimes. This investigation will help us indicate which types of fatal injuries fall outside the criminal justice system's realm of interest. This point is important because it is one of the main criticisms raised in the criminology literature is that CJS has taken a lenient approach to safety crime (see the discussion in Section 3.4.1.1).

### 8.4.1 'No Information' vignettes

#### 8.4.1.1 Vignette 1: The death of Anthony Saunders

The death of Anthony Saunders is an example of 'no information' type (BBC, 2013d). Anthony Saunders died on the 12th of August 2013 while working on the A24. I could not access information about the prosecution process, but the police appealed for eyewitnesses related to the case (BBC, 2013d). The most likely reason for this unsuccessful prosecution is that there were unsuitable conditions for a further criminal investigation. This may have been because the police could not find any witnesses or enough evidence to prosecute the defendant (BBC, 2013d; Prior, 2013). It can be seen one of the 'rare' cases was mentioned in the section 8.2.6

Another less likely explanation is that there is information, but I could not find it. However, the HSE's records, to which I had access, show that this is not a likely explanation because they do not have different or additional information about these kinds of cases. Therefore, it can be said that these cases went unpunished. This is evident in the case of Colin Ruddy.

#### 8.4.1.2 Vignette 2: The death of Colin Ruddy

The investigation process for the death of Colin Ruddy provides insights that help understand the characteristics of unprosecuted cases.

Mr Ruddy died on the 29th of January 2016 in Cambridge while working in the manufacturing sector. The HSE described the incident: 'The deceased was struck by an object' (Health and Safety Executive, 2017a). As discussed in Chapter 5, a relatively high number of 'no information' cases consisted of accidents resulting from someone being struck by or crashing into a vehicle or object. This study suggests that unprosecuted cases primarily relate to the transportation, farming and manufacturing industries. Agencies could not or did not investigate many cases for various reasons. A very likely explanation is that the circumstances of the places in which these accidents

occurred prevent agencies from continuing their investigations. Accordingly, agencies could not find evidence or witnesses that would help them decide whether there was a suspicious situation that would warrant opening a criminal investigation. Thus, it would be helpful to look at the HSE's policy regarding how it decides whether to open an investigation (Health and Safety Executive, 2015b). The main criteria for continuing an investigation are 'enough available information and whether it is worth [the] usage of resources' (Health and Safety Executive., 2015b). The HSE set out these grounds on its website (Health and Safety Executive, 2015b):

> The grounds for not investigating incidents that meet has where:
> - it is impractical to do so, for example, where key witnesses or other evidence is unavailable.
> - It is clear that all reasonably practicable precautions were in place at the time of the incident to reduce the risk of it occurring.

The HSE pays particular attention to workplace deaths that occur in particular industries, for instance, 'major hazards' and 'construction' (Health and Safety Executive., 2015). Aside from these categories, the HSE has determined the rationales for not investigating a case (HSE, 2020c):

> Part B - is used to record a decision to cancel an investigation where the investigation does not get underway due to inadequate resources/other developing priorities. For example, the investigating inspector may query the resources they have available to conduct the investigation on receipt of the incident, or a decision may be taken at the first review of progress with the investigation. Part C - is used to record a decision following consideration of additional information received. Additional information may be received in a number of different ways eg from the injured person 'complaining' that their incident is not to be investigated; from another enforcing body who has obtained information during the course of their own enquiries.

I have asked the HSE for more information about this case. Their records are limited, which reinforces the results of my research. The HSE indicated that this case was investigated, but HSE and (probably) other agencies could not extend the prosecution because it was unable to find information related to the accident, such as where and when it happened (22/08/2022[11]). Other likely explanations will be discussed in the following vignettes.

The HSE seems to consider two factors, resources and time, when deciding whether to open an investigation (Health and Safety Executive, 2015b; Health and Safety Executive, 2020c). These may be factors in other unprosecuted cases.

These vignettes show that death cannot be evaluated as a potential safety crime if:

- there is not enough evidence or information.
- there are no witnesses.

[11] The discourse gained through a Freedom of Information request.

- the accident happened in a less-important industry (according to the HSE's evaluation), apart from construction.
- contingent factors (natural causes) rather than a company's ignorance led to the accident (which relies on the agency's policy and the approach taken by agency personnel (such as coroners and HSE inspectors).

These vignettes provide insight into the policing of safety crime that a lenient approach has not helped to prevent crime and secure justice. It shows the limitation of the Compliance school's approach to punishment of corporate crime (for further information, see Section 3.4.2). This issue will be discussed further in Chapter 9.

Moreover, there is another type of unpunished case: 'no further information on court process' cases. Vignettes concerning this type of case will outline factors and agencies' roles in unsuccessful prosecution processes.

### 8.4.2 'No Further Information on Court Process' vignettes

In this section, I analyse three vignettes that use sheriffs' reports to explore agencies' roles in, and approaches to, WRDs.

#### 8.4.2.1 Vignette 1: The death of Russell Robinson

Russell Robinson died on the 30th of October 2011 while he was working as a saturation diver for Premier Oil (Buchan, 2014). Breathing difficulties while underwater caused his death. No individual or company was blamed or punished for his death.

Sheriff Anella Cowan investigated the case and prepared an eight-page report to support a prosecution. The sheriff gathered 'incontrovertible' evidence and witnesses' testimonies, and she emphasised the necessity of medical consultation. Some parts of her report help us to understand the agency's approach to the case (Cowan, 2014, p.3, author's emphasis):

> 7). **It appeared at the start of the Inquiry that there might be concerns over the equipment used on the dive. It can now, in my view, safely be said that no part of the equipment; the saturation diving system; the habitation chamber; the bell; the umbilical; communications; air supply or the operation or configuration of any of these caused or contributed to Mr Robinson's death.**
>
> 8) **Particular concern was raised about the fitting of Mr Robinson's neck dam.**
>
> 9) The evidence was that he had commented to Mr Stone that it was 'a bit tight'. He had selected it a few days before the dive. It was new but it had been trimmed to enlarge the circumference. It could have been trimmed further. It could have been exchanged for another. Mr Stone suggested to Mr Robinson that he exchange it. **He did not do so.**

> 10) **The manufacturers' advice, issued before this this, warned of the potential dangers of overtight neck dams.**
>
> 11) **As an experienced diver, Mr Robinson must be taken to have been aware of that advice**.

The question raised here is whether the sheriff examined the conditions (apart from being an experienced diver) that led Mr Robinson to prevent arranging neck dams. It seems the sheriff did not consider which condition prevented Mr Robinson checking equipment, even though Mr Robinson's death was possibly related to the neck dam (Cowan, 2014, p.4):

> 13. **One of the concerns raised on behalf of Mr Robinson's family was the operation of the 'buddy system'. That was not explored in detail because it was out with the relevant considerations for the Inquiry** [author's emphasis].

The sheriff also failed to pay attention to the 'buddy system' and the size of the bell. The sheriff testified that this was because they were not factors that contributed to the accident. However, the sheriff collected testimony from various experts to determine the causes that led to the death (Cowan, 2014, p.6):

> 29. **He was not able to identify the actual fatal cause or the factors which had contributed to form the fatal cause.**
>
> 34. Dr Grieve did find signs of asphyxia. There was congestion of the face, cyanosis of the face and neck and petechial haemorrhaging. **There are many potential causes of asphyxia**, according to Dr Grieve, ranging from smothering, through crushing of the chest stopping inhalation, to lack of breathable atmosphere to external compression.
>
> 35. Dr Grieve had a concern over the tightness of Mr Robinson's neck dam. But could not be satisfied [author's emphasis].

The sheriff drew on findings that indicate that the reasons for the death were uncertain. The collected evidence relied on possibilities, and this, together with witness testimony, led agencies to evaluate this case as an accidental death. Police agencies (the sheriff) decided that there was no negligence on the part of companies or managers regarding this accident. The accident happened because of uncertain factors.

#### 8.4.2.2 Vignette 2: The death of Stephen Thomson

Stephen Thomson died in September 2012 while working on a roof in East Dumbarton. Two companies (Glasgow Steel Nail Company Ltd and Euroscot Contractors Ltd) were involved in the case. The inquiry heard witnesses' testimonies and evaluated other documents four times between November 2013 and January 2014.

The way Stephen Thomson died was described in the report as follows:

> Stephen Thomson then lifted the fourth asbestos cement sheet and as he was handing it to the others to take to the hoist, he lost his balance and his footing and fell through the hole where the sheet had been. His head struck a piece of machinery, and he landed on the floor 3.5metres below between a wall and a machine in an enclosed space and with his head in a downward position. It was not possible to move the machine to reach Stephen Thomson who was on his knees with his head into his chest. It was not possible to access him to give assistance (Wood, 2014, p. 7).

According to the report, he may have been wearing a helmet, but this did not change anything. The sheriff indicated that 'He had a cut to the back of his head which suggests that his hard hat may have fallen off when he fell. His employees tried in vain to access him, but a heavy machine blocked their attempts' (Wood, 2014).

The sheriff comprehensively and objectively evaluated the case by indicating the irresponsible actions taken by companies and the HSE, which relied on witnesses' testimonies and documents. The sheriff indicated how this accident could have been avoided and outlined the company's wrongful actions (Wood, 2014, p.4):

> (3) (…) In particular, Euroscot Contractors Ltd should have followed safe working practices, namely:
>
> (i) The erection of scaffolding around the perimeter of the building.
>
> (iii) Installation of safety nets and bean bags to the underside of the roof
>
> (…) the following were defects in the system of roof working by Euroscot Contractors Ltd which contributed to the death:
>
> (i) Lack of suitable and sufficient risk assessment in respect of work at height.
>
> (ii) Lack of fall mitigation in the form of nets and bean bags inside the workshop.

Moreover, the sheriff identified the HSE's negligence during the investigation process. The sheriff considered that the HSE should have stopped the roofing work before the accident happened:

> There were facts which **were relevant to the circumstances of the death namely that more could have been done by the HSE in trying to identify the duty holder following the receipt of a serious complaint** (with locus details and photographs) from a concerned member of the public on the Tuesday before the accident on the Saturday 29 September 2012.
>
> Soon after the accident on 29 September, Mr Richmond was contacted by the Police and attended on site. HSE issued a prohibition notice to prevent further work with a direction to leave the site undisturbed. The roofing work was completed some months later by Euroscot Contractors Ltd, who employed a sub-contractor, Mark Whittingham, who put other safety measures in place, including scaffolding, handrails, crawler boards, safety harnesses, safety netting and bean bags. The work was completed satisfactorily (Wood, 2014, p.3, author's emphasis).

A witness reported that there were unsafe working conditions, such as 'no edge protection or scaffolding', before the accident (Wood, 2014, p.7). The HSE was informed about this issue on the 25th of September (Wood, 2014, p.8):

> Ms Martin concluded that there were not sufficient measures in place to prevent falls. There should have been a combination of removing the sheets from below, installation of perimeter guardrails, safety netting to the underside of the roof and staging to spread the load on the old fragile roof sheets.

According to the sheriff's report, the actor mainly responsible for the accident was Euroscot Contractors Ltd (the contractor company). The sheriff stated (Wood, 2014, p.8):

> (10) The HSE **did not recommend proceedings against Euroscot Contractors** Ltd. Although there were clear breaches of health and safety regulations (…) Stephen Thomson was responsible as principal of the company and in the circumstances, it was not appropriate to instigate proceedings.
>
> In the intervening period before the accident, HSE **did not identify the duty holder for the works in question** and accordingly, no contact was made to discuss the circumstances of the works and possibly halt it. The Crown submitted that the death may have been avoided had the HSE made prompter and more effective investigations to identify the duty holder for the works [author's emphasis].

Moreover, the defence team for Euroscot Contractors Ltd agreed with the Crown about the irresponsible activities carried out by the company and the HSE (Wood, 2014, p.12):

> She went further by suggesting that had Lesley Gordon contacted Glasgow Steel Nail Company Ltd on Friday before the accident, having been given certain information at 1010 hours on the Friday by Iain Brodie, the work may have been stopped on site or additional safety measures put in place, and that such a reasonable precaution might have prevented the accident and indeed, the death of Mr Thomson.

The last part of the report provides a clear picture of the prosecution process and police agencies' approaches to the case. Therefore, it is helpful to include some parts of the conclusion here to understand the agencies' roles and approaches to the case (Wood, 2014, p.14):

> There is no doubt that Stephen Thomson died in an accident **which should not have happene**d.
>
> **The more difficult part of this Inquiry relates to the involvement of the HSE and as to whether the court should make findings under sections 6(1)(c) and 6(1)(d).** The public, I am sure, would be concerned that where a serious complaint with locus details and photographs is made to the HSE **at 1241 hours on a Tuesday about work being carried out on a roof and potentially having an effect on health and safety, that those holding a duty of care are not notified by the HSE prior to the accident and the consequent death on the following Saturday morning.** That is what happened here, and it is at least arguable, that if positive action had been taken and the duty holder identified, the accident **may well have been avoided.**
>
> In addition, I am not satisfied on the evidence led and applying the test of the balance of probabilities that the defect 'contributed' to the accident resulting in the death. **It might be argued that** if there were defects in the HSE system of working, the accident could have been prevented but the test here is whether it 'contributed' and on balance, I am not able to make such a finding [author's emphasis].

The police agency argued that companies and the HSE were at fault in this case, and this negligence caused the worker's death. However, the findings relied to some extent on assumptions, which can be seen in the language used and reproduced above.

#### 8.4.2.3 Vignette 3: The death of Ian John Leitch Black

Ian John Leitch Black was working in Ayrshire as a contractor (for B and B Property Maintenance Ltd) with Mr George Brown on the day of this accident (the 22nd of July 2013). They were doing repair work that 'required that old render be removed, a crack be repaired, a mesh fixed to the wall and finally a new render finish applied to the gable wall' (Murray, 2016, p. 5). The accident and its possible cause were described in the sheriff's report:

> Mr Black mixed a quantity of render and passed this to Mr Brown to apply. **It was a warm day and the render was hardening too quickly, because of the prevailing temperature.** Mr Black sought initially to dampen the render on the gable with a hose. He then ascended a ladder which he placed to the left of the tower scaffold to assist in the application and smoothing of the render. He did not secure the ladder which was set on a tarpaulin. **The tarpaulin had been laid out to catch falling render and was wet following the wall having been hosed down.** Mr Black was the more experienced contractor and was responsible for the system of work and how the render was to be applied. His use of the ladder **was contrary to the guidance published by the HSE in** 2005 IND402 Safe use of Ladders and Stepladders and repeated in HSE 'pocket card' INDG405, to the effect that ladders should be secured, placed on firm level ground and that the ground should not be slippery.
>
> Mr Black applied some render to the wall, descended the ladder and re-ascended with a float to smooth the newly applied render. To undertake this task, he stepped from the ladder and placed his feet on the outside rail of the tower scaffold. He hooked his right arm around the tower scaffold and smoothed the render. As he stepped back onto the ladder it slipped. Mr Black initially hung on to the tower scaffold before he fell to the ground, a distance of some 12 feet. **Mr Black was the author of his own misfortune** (Murray, 2016, p. 6, author's emphasis).

The part of the report that discusses negligence and the actor responsible for the failure in the eyes of police agencies is important. The first point worth mentioning here is that the sheriff perceived the case to be caused by natural circumstances (it was a warm day) and the worker's action (Mr Black was the author of his own misfortune), which ultimately led to this death. The language chosen to define the causes provides insight into the agency's perception of WRDs. Tombs and Whyte (2007) emphasised a general tendency to determine the causes of safety crimes by noting that workers and their actions are seen as the main problem. This discourse can be seen as an instance of this approach. Further, this approach has become one of the determining factors in officially defining WRDs as crimes or accidents.

The second point worth mentioning is that negligence was identified: 'His use of the ladder was contrary to the guidance' (Murray, 2016, p. 5).

The sheriff determined the causes of death to be 'pulmonary thromboembolism', 'deep vein thrombosis' and 'fractured left hemipelvis' (Murray, 2016, p. 9). Additionally, the sheriff stated that this accident would not have happened if some safety measures had been taken:

> A reasonable precaution by which the death **may have been avoided would have been by Mr Black taking reasonable care** for his own health and safety: this by following a safe practice in

> applying the render to the gable wall. In particular Mr Black should not have worked from the outside of the tower scaffold without precautions to prevent a fall and the ladder he was using should have been secured or held in position.
>
> (…) if any, in any system of working which contributed to the death or any accident resulting in the death:
>
> Having established a safe system of work using a tower scaffold, Mr Black as a consequence of his concern about the rendering 'going off' did not follow safe practice by failing to secure the ladder and placing it on a wet tarpaulin. This resulted in the ladder slipping and his falling to the ground. **Mr Black also failed to follow a safe practice by working from the outside of the tower scaffold without precautions to prevent a fall** (Murray, 2016, p. 2, author's emphasis).

Mr Black was in hospital for eight days after the accident before he died. Mr Black's family raised some concerns about his treatment and care. The family's main concern was whether Greater Glasgow Health Board had paid enough attention to Mr Black to save his life. The sheriff indicated that even though this information was found, it was out of the scope of the report: 'In these circumstances I was invited to make no finding in relation to the medical care under this heading' (Murray, 2016, p. 12).

According to the report, the medical care at the hospital did not contribute to the worker's death, even though there was a failing (Murray, 2016), which was that Mr Black's medical record was not updated with information about his current condition because it was a busy shift for the medical staff. The police agencies did not consider the medical care received by Mr Black to be the main factor that led to his death. Two professionals (Ms Don, the lead nurse for orthopaedics, and Mr Blyth, a consultant orthopaedic surgeon) asserted that nothing could have changed Mr Black's situation (Murray, 2016, p. 11).

The company that gave the job to the contractor was not involved in the case. It is unclear why police agencies did not investigate the actors responsible for negligence and were not involved in the case. When we compare this case with the Nikolai Valkov case, both companies hired contractors, but only one was punished, and the wrongdoing was considered corporate manslaughter. However, one explanation is that in Nikolai Valkov's case, there were workers other than the owner of the company, while in this case, the contractor was also the worker.

In general, police agencies paid attention to the main causes that led to the death and how they contributed to the accident. This case supports the argument that many workers' deaths are not seen as corporate manslaughter or safety crimes punished under health and safety regulations because agencies decide that natural reasons (such as the weather) or a responsible actors' fault have led to the deaths and that companies cannot be blamed for negligence.

In other words, if a death was caused by contingent factors (natural causes or failings by workers), and if police agencies do not evaluate negligence as sufficiently serious, these actions cannot be

evaluated as crimes. Some researchers (Almond and Colover, 2012; Tombs and Whyte, 2007; Pearce and Tombs, 1998) highlighted this situation as a significant ongoing problem in the treatment of safety and corporate crimes in the UK.

## 8.5 Accidental death decision vignette

This section presents one illustrative vignette illustrating coroners or coroner court's accidental death decision. I will do this by analysing coroner' report and media news reports. Coroner reports help us to understand police and non-police agencies' responses to WRDs. The importance and ambit of these coroners' reports were explained in Chapter 4. I reached only information of inquest processes in a considerable number of cases (see Chapter 5). I could not find any information of criminal charge, and in most of these decisions present a lack of criminal intent for police agencies. Even though there has been a possibility of a criminal charge of corporate manslaughter or other safety crimes in accidental deaths verdict cases, it is valid only for a few cases, such as for unlawful killing verdicts (Slapper, 1993). It is likely to said that coroners' or coroner courts' decisions of accidental deaths have not contributed to securing justice in corporate offending (Slapper, 1993; Wells, 1991). However, a few cases resulted in a criminal charge after the coroner inquest process and decision (see 8.2.5 and 8.2.4 and Chapter 5).

This category was occasionally analysed in chapter 5, thus, one of these examples can help to provide insight into the coroner's approach.

Tombs and Whyte (2007) broadly discussed the criminal justice system's ability and intentions regarding work-related corporate offending, highlighting the importance of this issue. They scrutinised the logic that explains why some work-related violence is not included in the prosecution and punishment processes. The analysis of illustrative vignette provides insights into that agency (court)'s scant attention to WRDs.

### 8.5.1 Vignette 1: The death of Peter John Buckle

Peter John Buckle died on the 23rd of March 2015 while working for Wayland Farms Ltd. The accident was described in the coroner's report (Norfolk Coroner Court, 2015, p.1):

> The telehandler was not working so it was suggested the rubbish was to be thrown into the trailer by hand. It was then felt the sides of the trailer were too high. It was decided to prop open the tailgate with a post. A post was propped against the tailgate, but it slipped causing the tailgate to fall resulting in injury to Mr Buckle.

According to the coroner and HSE inspector, the wrongful action here was that the telehandler and grab did not work (George, 2015: Norfolk Coroner Court, 2015). Subsequently, workers used unsafe methods of throwing rubbish (George, 2015). The main reason for using this unsafe method was that there was no alternative safe plan (Norfolk Coroner Court, 2015). The coroner articulated her perception of the negligence in the report (Norfolk Coroner Court, 2015, p.1):

> […] namely, to throw the rubbish over the side of the trailer; in that the trailer was reversed to the rubbish site, a telephone call was made to 2 other employees to assist, and protective equipment was being obtained. This left Mr Buckle to assume the work was to be carried out in this way, whether or not the Site Manager was of the view the method of work was still under consideration. In any event, this method of carrying out the work **was blatantly unsafe.**
>
> **(**2) **The employees left at the site of the rubbish, decided on a third method of carrying out the work, without any thought for health and safety. Although health and safety induction training had been undertaken and managers had received further training a health and safety culture was not apparent from the evidence, particularly at 'ground level'** [author's emphasis].

This approach shows unsafe working conditions and an obvious disregard for life-saving programmes and taking responsibility. However, these factors were perceived by the coroner as low-level negligence. Using the unsafe method was seen as an omission of the worker.

The coroner reported her concerns to Wayland Farms Ltd and the HSE on the 3rd of November 2015. The company responded to this report by outlining the measures they had taken, such as launching a training programme (Wayland Farms Ltd, 2015). In addition, the company stated that they had provided additional training for managers about their responsibilities and the health and safety of workers.

On the one hand, the coroner's report and the company's efforts can be seen as positive attempts to protect workers' lives in the future. On the other hand, there is no evidence this kind of attempts help to prevent WRDs considering similar reasons that leads to deaths occur every year.

There have also been other illustrative cases of companies that were punished following coroners' reports (BBC, 2017c; O'Mahoney, 2017). This can be observed in the prosecution processes for the deaths of Paul Littlewood who died on the 8th of July 2014 and Richard Laco who died on the 6th of November 2013 (O'Mahoney, 2017). The coroners articulated the circumstances of the deaths in both of these cases and shared their concerns with the relevant bodies.

The coroners' main concerns were a lack of training and information and unsafe workplace conditions. The HSE paid close attention to the reports, communicated with the relevant parties, organised courses, and updated regulations. However, there are some examples of ways in which they did not pay attention to the coroners' reports, such as not taking any further action.

Other coroners' reports can be seen as signs of unsuccessful regulation. They also show that companies did not take safety conditions sufficiently seriously. Accordingly, these reports show that the criminal justice system prefers to take an approach based on a negotiation between organisations.

## 8.6 Conclusion

The examination of 14 vignettes shows that each category provides narratives, and these narratives help to understand the factors and reasons for the low number of corporate manslaughter convictions.

The vignette helps to interrogate several accidental death decisions made by police agencies, which reveal that police and non-police agencies focused on technical failures as the causes of death. Subsequently, contingent factors were seen to be the main causes rather than companies' and/or managers' negligence.

The analysis of the gross negligence vignette shows that the CPS's approach to some WRDs can be evaluated as a factor influencing the low number of convicted corporate manslaughter cases. This is because the CPS considers it to be more appropriate to punish small companies' wrongdoing as gross negligence manslaughter rather than punishing them for corporate manslaughter.

The vignettes concerning HSW convictions show that punishing companies has not been a problem for police agencies, regardless of the number of managers and companies involved. It is worth noting that health and safety law enables personal liability (Health and Safety at Work etc. Act 1974) contrary to CMCH Act. And these successful convictions were composed of cases involving small companies. Additionally, police agencies have decided that there is insufficient evidence to punish companies for corporate manslaughter. Accordingly, agencies have taken a lenient approach regarding WRDs, compared to corporate manslaughter convictions. The outcome for this category allows comparison between safety crime convictions. Moreover, it will provide an opportunity to discuss the efficiency of the CMCH Act 2007. This discussion will be presented in the final chapter. The findings of two other vignettes (the death of Kevin Dorman and Neal Edmonds) indicate that this is one of the reasons for the low number of corporate manslaughter and safety crime convictions. This conceptualisation oversimplifies the factors; negligence and irresponsible actions by companies lead to deaths that can be labelled as crimes rather than accidents.

The analysis of five no information and no further information on court process vignettes helped us understand some of the reasons for the low number of corporate manslaughter convictions by considering agencies' roles and factors related to identifying safety crimes.

In reviewing the literature, some researchers (such as Friedrichs, 2015, Pearce and Tombs, 1998 and Tombs and Whyte, 2007) indicated the reasons (problematic approach and policy of agencies and boundaries of law and regulation) behind why criminal justice system has not investigated and punished many cases (see Section 3.4.1). I will turn to these issues in Chapter 9. As I stated in the introductory chapter, the treatment of safety crimes as a subset of corporate crimes is vague, and more than one factor is needed to explain this complicated and problematic picture. Analysing these vignettes has assisted in clarifying this picture.

# Chapter 9 Discussion and Conclusions

## 9.1 Introduction

In this chapter, a summary of the research questions and the key findings is first provided; then the findings are considered in the light of theories discussed in the literature review. Additionally, the practical implications of the findings and opportunities for further research are discussed.

*Research questions*

*This thesis* identifies problematic issues related to safety crime: low levels of attention to safety crime, the seriousness, the debate on defining 'crime' and 'criminal', the lack of reliable and useful official data, the low number of corporate manslaughter convictions and the lenient approach adopted by the authorities. Such crimes have not been treated seriously by the criminal justice system (CJS), even though corporate crime causes more harm to society than street crime. This thesis was designed to examine these problems by answering three questions:

*1) How have UK government policy and legislation against corporate crime been implemented in practice since 2008?*

*2) Why can some corporate violence that resulted in deaths be seen as safety crimes while others cannot?*

*3) What are the factors and roles of agencies that influence the prosecution process and the final decision?*

This research project is, to the best of my knowledge, the first doctoral thesis to investigate the process of prosecuting and punishing companies and managers in cases involving more than 750 fatal injuries, to analyse the death of Nikolai Valkov and the MNS Mining accident through case studies and to use 14 crime vignettes that depend on publicly available and unavailable sources. The thesis provides unique findings to answer the three research questions and has made two important contributions to the safety and corporate crime literature. First, my research helps to reify safety crime by indicating the rates of conviction, investigation and not guilty verdicts in cases of safety crime in the UK. Second, as set out in Chapters 6, 7 and 8, it has determined factors and the police and non-police agencies' role in reaching the result of a fatal injury investigation and the reasons for deciding whether a case is to be treated and labelled as a crime or not.

## 9.2 Key findings

*Chapter 5* makes an original contribution to the literature by examining the investigation and prosecution processes of 759 work-related deaths (WRDs) and categorising them into five types (covering eight years period: 2008-2016) to help answer the research questions.

Statistical and document analysis show that the HSE and police investigated 611 workers' deaths, and the courts punished a small number of companies responsible in these cases (349 out of 611) under regulations and health-and-safety laws instead of the Corporate Manslaughter and Corporate Manslaughter Act (CMCH Act). The CPS and the courts are not inclined to consider cases as corporate manslaughter. ***Figures 5.19 and 5.21*** helps to summarise this point in numbers.

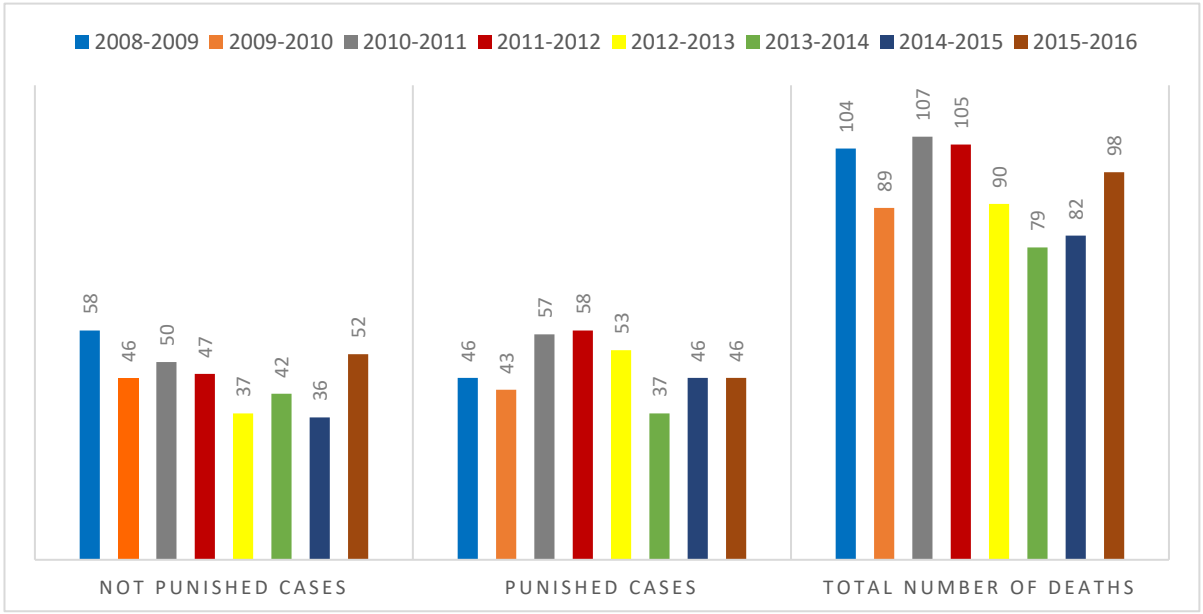



*Figure 9-1 The treatment of workplace deaths by the courts (2008-2016)*

The general pattern is that the number of punished and unpunished cases are close to equal. The highest average differences can be observed in the period 2008-2009, when punished cases (46) were lower than unpunished cases (58), and 2012-2013, when punished cases (53) were higher than unpunished cases (37) within the eight years of 2008-2016.

***Figure 9.1*** shows the critical role that the HSE and police played in securing justice in some workplace deaths. On the other hand, the courts and CPS played an important but negative role in this process. ***Figure 5.20*** (see, p.107) shows that institutions did not approach every workplace death as potential corporate manslaughter. Compared to police agencies, the HSE perceived WRDs as potentially a more serious crime. The police paid close attention to WRDs as there were many investigated cases. However, it is likely that the police did not play a crucial role in

considering WRDs as crimes. The CPS and courts played an important role in considering cases as corporate manslaughter.

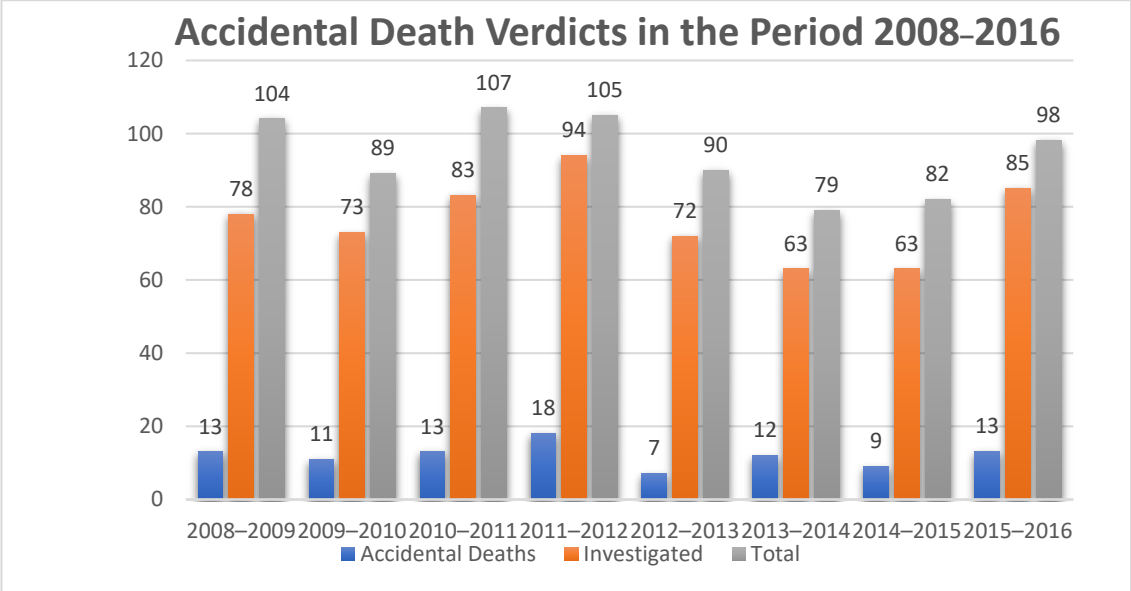



*Figure 9-2 Total number of Accidental Death Verdicts, Investigated and All Cases*

**Figure 9.2** shows that, in the period under review, almost 16 per cent of investigated cases resulted in accidental death verdicts in courts or by coroners on average. The number of accidental death verdicts shows the response of the criminal justice system in securing justice for safety crimes. Importantly, the number of accidental death verdicts (including, unlawful killing, accidental death, misadventure, narrative and open verdicts) is one of the reasons behind the low number of convictions. The findings show that there had been no criminal charge information for these cases. A few cases resulted in a conviction (see Chapters 5 and 8), but the number of this kind of case is limited.

Cases convicted under health-and-safety law comprised 46 per cent of all WRDs. Punishing a company under the HSW Act is more straightforward than under the CMCH Act. This situation can be observed in the relatively high safety crime conviction rate: 90 per cent of punished cases. Companies and individuals can be charged with relatively large fines and prison sentences under the health and safety act. However, the punishment imposed is more lenient than in the case of corporate manslaughter. This lenient approach can be observed throughout Crown Censure orders. Agencies gave Crown censures in some cases due to the limited power of police and non-police agencies and the boundaries of the act. For instance, a Crown censure was imposed on the Navy over the death of Neal Edmonds (O'Leary and Elmes, 2018). This is an example of a case where the CMCH Act was not applied even though there was punishable negligence.

Chapter 5 indicates that the agencies believed that accidents could be avoidable and were tragic. On the one hand, this shows that the agencies accepted that companies' or managers' negligence led to the event, and they took the WRDs seriously. On the other hand, the seriousness of the negligence and actions were not enough to consider cases as corporate manslaughter.

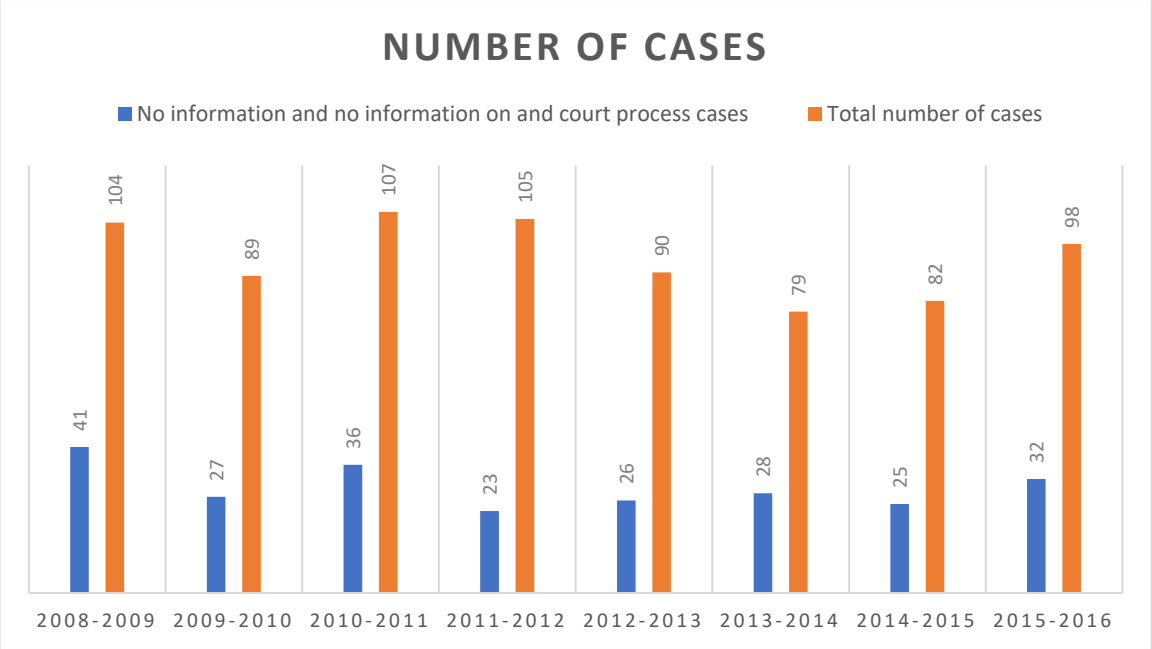



*Figure 9-3 Number of 'no information' category cases compared with the total*

The 'no information' category is as important as the other two categories (accidental death and convicted safety crimes) in providing explanations for the research questions and is discussed in Chapter 5. These cases can be seen as hidden but critical cases in the criminal justice system. They occupy an important place (31.4 per cent of all cases) in the treatment of safety crimes.

The possible reasons gleaned from the analysis are that (i) police and non-police agencies did not find any suspicious situations that would allow them to open a criminal investigation; (ii) even though there were reasons to open an investigation that forced them to continue, police and non-police agencies could not find witnesses or evidence and thus closed the case; and (iii) I could not obtain information even though there was a criminal investigation and court process, although this is a less likely explanation.

I obtained data about 17 cases that occurred in different years (2008, 2009, 2011, 2012, 2014, 2015 and 2016) from the HSE via a Freedom of Information (FoI) request (22/08/2022). The data indicated that agencies did not impose punishment in 15 out of the 17 cases and did not take enforcement action in 9 of those 17 cases. Additionally, police investigated only four of the 17

cases, and these cases went unpunished. HSE stated that the agency had no information about 4 out of 17 cases while no further information on court process about 2 out of 17 cases.

Each of these groups – 1) Cases under corporate manslaughter law; 2) 'No information' and 'no further information on court processes' cases; 3) Cases under health-and-safety acts and regulations; and 4) Gross negligence manslaughter (but not corporate manslaughter); 5) Accidental deaths (inquest process and verdicts) – provides a narrative that helps us understand how police and non-police agencies responded to work-related corporate offending and why some cases were evaluated as corporate manslaughter and others were not. These were analysed in Chapters 6, 7 and 8.

It would be helpful to summarise the important findings of Chapter 5. Police and non-police agencies investigated 81 per cent of all cases but punished only 63 per cent of them (51 per cent of all cases). While convicted cases under health-and-safety regulations comprised 90 per cent of punished case (46 per cent of all WRDs), there were only 24 corporate manslaughter and 13 gross negligence manslaughter convictions (less than five per cent of all cases). Agencies failed to evaluate almost 32 per cent of all cases as potential safety crimes. Accidental death cases comprised 16 per cent of all cases. Agencies gave prison sentences and huge fines (valid for cases happened after 2010) for safety crimes even though these cases were limited, and prison sentences were generally suspended (see Section 5.10 and ***Figure 5.19***).

Qualitative case studies are used to deepen the analysis of the characteristics of guilty and not guilty decisions of corporate manslaughter. The first case is an instance of a corporate manslaughter conviction. This is the first PhD thesis in criminology to investigate the death of Nikolai Valkov by analysing court documents and conducting semi-structured interviews. This chapter aims to determine factors and the agencies' role in the final decision through document analysis. The chapter shows that the main factor was sufficient and detailed evidence that enabled the action to be legally defined as corporate manslaughter. The evidence gathered assisted the court in making a corporate manslaughter verdict by clarifying the following issues. The companies lacked qualified health-and-safety staff and workers did not have sufficient experience in the sector. In addition to this Koseoglu Metal Works Ltd and Ozdil UK Ltd did not provide adequate training for their employees. The relationships between the companies and workers were informal and unprofessional. Specialist and witness statements were used as supporting evidence. The critical point was that the companies did not consider the warnings of the HSE (this was an issue particularly for Ozdil Investment) and no safety measures were in place.

The CPS articulated the level of harm in court and sent the case to the public prosecutor as a possible corporate manslaughter case. The CPS's intention to punish the companies for corporate

manslaughter can be observed from the transcription of court records. However, the CPS's contribution is not as important in securing justice as that of other police and non-police agencies. The judge played an important role by handing down huge fines and prison sentences that were not suspended.

The most determinative factor in securing justice was evidence and the process of its collection. A subsidiary factor was the close cooperation between the agencies. However, there is a strong relationship between these factors.

The factors that made the investigation process successful and enabled the actions of the companies to be defined as corporate manslaughter were: (i) gathering strong and sufficient evidence; (ii) the agencies' approach to the case (particularly the judge) in that they took the irresponsible actions seriously. For instance, the most severe punishment (a prison sentence and a huge fine) was applied, and the prison sentence that was handed down was not suspended; and (iii) the close and serious attention of the HSE and police. However, it is a rare corporate manslaughter conviction case that is taken seriously by the agencies.

Chapter 7 covers the second case study employed in this thesis. The MNS Mining case represents not guilty decision of corporate manslaughter. This chapter scrutinises factors and conditions beyond the problems indicated in the literature, all of which played a role in failing to secure justice by implementing corporate manslaughter law in this instance. These factors and conditions can be identified as follows: (i) conflicts in the evidence collected (unsatisfactory and questionable); (ii) areas of the mine were not comprehensively investigated before or after the incident; (iii) the company and manager hired experienced and professional lawyers; (iv) complicated technical issues; (v) an unprofessional decision-making process; and (vi) the lack of high-level attention from the HSE before the accident.

This analysis shows us that the senior management test did not help to secure justice though the court discussion shows that it is difficult to say whether senior management test was applied. Corporate liability remained an ongoing problem in this case because the case went unpunished. The MNS Mining case provides insights into factors such as the possible views of experts, having a successful defence lawyer and the role of agencies in these types of non-punished cases. Several factors affected the jury's decision. This result involved an examination of the CMCH Act and how it applies justice.

*Key findings of Chapters 6 and 7*

Analysis of the Nikolai Valkov and MNS Mining cases provides insights into the characteristics of the actions and the actors, which affected the last decision. These two case studies indicate some of the reasons for the guilty and not guilty decisions:

- Clear and strong evidence and testimony were primary factors for conviction (Nikolai Valkov), while in the MNS Mining case, the complicated prosecution process and contradictions in testimony and weak evidence were important factors.
- There was an untrained worker in the Nikolai Valkov case, while there were experienced and trained workers in the MNS Mining case.
- Weak health-and-safety background (Nikolai Valkov).
- The close attention of agencies can be evaluated as a secondary factor in both cases.
- The jury was convinced by the CPS to return a guilty decision (Nikolai Valkov; unlike the MNS Mining case).
- The companies had an experienced and powerful defence team (MNS Mining case), while in the Nikolai Valkov case, companies had an inexperienced defence team.
- The complexity of the case (MNS Mining case).

However, there are similarities between these cases:

- The seriousness of these two cases was the same for agencies, as can be seen from the fact that they were prosecuted under the CMCH Act even though the action led to event (caused deaths in both cases) was considered differently; as guilty in the first case and not guilty in the second case.
- The lack of qualified health-and-safety staff.
- The size of the companies was similar – small.

*Chapter 8* examines police and non-police agencies' responses to WRDs by exploring the narratives and patterns of prosecution processes through 14 crime vignettes that differ from the two case studies. To the best of my knowledge, a study that analyses various types of WRDs' prosecution and punishment processes by focusing on crime vignettes has not been conducted before in a PhD thesis in criminology. This chapter uses crime vignettes to understand the factors that determine an agency's role in that a case a safety crime or not a potential crime. Chapters 6 and 7 look at one types of investigation result described in Chapter 5 (cases prosecuted under corporate manslaughter law). This chapter analyses the remaining types.

On the one hand, agencies prefer to negotiate with companies and other organisations rather than punish them. Crown censure orders, coroner's reports and not guilty decisions show that agencies adopt a policing strategy that coincides with the compliance school's arguments (see Gray, 2006; Hawkins, 1990) rather than a punitive policing strategy (see Chapter 3). On the other hand,

coroner's reports and the HSE's efforts can be evaluated as extending beyond securing justice in these cases.

Importantly, agencies overwhelmingly perceive failures as low-level negligence, which means they cannot be considered crimes; and some failures are attributed to workers.

Chapter 8 enables us to determine further features of convicted health-and-safety cases via five crime vignettes: (i) agencies easily found actors responsible for negligence; and (ii) the evidence was satisfactory and clear. The important features are: (iii) the evidence was not sufficient for a corporate manslaughter conviction; (iv) the judge made a reduction in the fines (see 8.2.1 and 8.2.2; similar findings are highlighted in Chapter 5); and (v) some accidental death decisions may be converted to a guilty verdict later, mostly following further investigation by the HSE(but the number of these cases is very limited). In addition to this, some convicted companies had poor safety records.

The 'no information' and 'no further information on court process' vignettes provided insights into how these cases turned out the way they did. These factors and reasons provide direct answers to the second research question; they can be summarised as follows:

- The HSE does not pay close attention to WRDs that occur in sectors other than construction and manufacturing.
- Cases may not be investigated if there is not enough evidence, information or witnesses (see Chapters 5 and 8).
- The condition of the accident area does not allow the police and non-police agencies to finish their investigation in some cases.
- If the agencies consider that contingent factors (natural causes) led to the accident, they tend not to open a further criminal investigation; some cases are closed in the court process ('no further information' cases are instances of these results).
- In some cases, the HSE serves a prohibition notice on the company rather than sending the case to the police and on to court.

These factors show why some WRDs are not seen as crimes.

The gross negligence manslaughter vignette indicates the possible reasons behind this verdict and the characteristics of this vignette that led to the CPS recommending gross negligence manslaughter sentences instead of corporate manslaughter in some cases. This suggests that the CPS's role and policy are influential factors in delivering gross negligence decisions instead of verdicts of corporate manslaughter.

*Key findings of Chapter 8*:

- The perception of safety crime as a technical failure can be observed in not guilty verdicts, accidental death verdicts and the 'no information' and 'no further information on court process' vignettes.
- Even though the coroner or judge considered the action to be because of negligence, mostly police agencies did not impose punishment.
- A few accidental death verdicts can be changed later as guilty verdicts.
- The only obvious difference between safety and corporate manslaughter investigations is the level of seriousness of the negligence perceived by police and non-police agencies.
- Strict guidelines, which are set out in the legislation, and the policy of agencies (mostly HSE and CPS) make it difficult to give guilty verdicts for corporate manslaughter and safety crimes.

***Discussion***

Criticisms related to the implementation of corporate criminal law – as determined in Chapter 3 (Literature review) – include: Companies punished under the CMCH Act are small (Hébert Bittle and Tombs, 2019; Tombs, 2018). This thesis contributes to this criticism by indicating that few big companies was punished under health-and-safety regulations. For instance, Porvi Construcciones y Contratas S.L. was punished with a £3,000,000 fine (Health and Safety Executive, 2017b), while Total UK was fined £1,400,000 (see further instances in Section 5.10). Furthermore, it can be observed throughout that a small number of cases involved fines of £500, 000 and above (see Figure 9.4) and a low number of prison sentences (see Figure 5.19). These findings coincide with one of the key claims of critical criminology (see 3.3.1. The crimes of the powerful within critical criminology) that larger organisations and powerful actors do not go to court and get punishment.

The analysis of two cases (see Chapters 6 and 7) provides findings that the police agencies came close to a decision under complicated and challenging conditions. Criminal activity that results in a worker's death may be punished for corporate manslaughter under the following circumstances: there should be severe (according to the agencies) and gross negligence (enough to convince a jury), police and non-police agencies must pay a high level of attention and a company should have an ordinary defence team. However, it is difficult to say which, if any, individual factor plays a crucial role in determining a case as corporate manslaughter or not. The MNS Mining case (an instance of a not-guilty decision) shows that negligence is not enough to suffer a guilty decision. In other words, any negligence must be very serious (a relative criterion) and proven by agencies. This refers to a structural problem derived from the content of the CHMC Act. The case highlights the central role of non-police agencies in failing to secure justice and prevent safety crime. The HSE's investigation and findings and the PUWER company's application to the council were the subjects of crucial discussions in the court. Another important factor was the jury's role in the

case. They evaluated the complicated issues and gave a not guilty decision. The defence team as a third-party actor (apart from the agencies, victims and companies) played a critical role in the final decision by questioning evidence and the agencies' approach, and indicating other possibilities for the jury. This analysis shows how a powerful company or individual may affect the final decision. The criticism of critical criminologists highlights this issue, that powerful companies and managers can avoid conviction in the criminal justice system (see Punch, 2000 and Section 3.4 of this thesis). It is one of the important contributions of this thesis to debates of why some corporate wrongdoing can be seen as safety crime while others are not. The second case study (MNS Mining case) shows the challenges in making connections between the negligence and deaths, the effect of professional lawyers and the role of agencies in arriving at a not guilty decision which coincide with the arguments of researchers such as Punch (2000) and Waddington, Badger and Bull (2005). These researchers (Tombs and Whyte, 2007; Waddington, Badger and Bull, 2005; Punch, 2000; Punch 1996) argue that it is difficult to determine and punish corporate violence for several reasons: difficult proving process of negligence in accidents (indirect indicators), professional and powerful lawyers and insufficient structure of act. However, it is difficult to say this approach is valid for each case. For instance, a clear criminal record or being a businessman did not provide any advantages for owners to avoid sanctions in the first case (the death of Nikolai Valkov). Besides, it should be mentioned that the owners of the companies that were involved in the death of Nikolai Valkov are not very powerful people.

The analysis of this case (MNS Mining case) relied on transcripts of the court hearing and publicly available sources. We did not hear the voice of influential actors in this case. Interviews would have provided more data, but unfortunately the Covid-19 pandemic and inherent difficulty of the subject prevented interviews from being conducted.

This thesis argues that corporate liability and the structure of the Act remained inoperable in some cases. It can be observed in the MNS Mining case that company directors (Gerald Ward and Maria Nora Seage) and shareholders were not blamed and automatically avoided possible convictions when police agencies focused on Mr Fyfield as manager, and he was not punished, since the company was found not guilty for corporate manslaughter. This situation shows the importance of criticism of the efficiency of the CMCH Act (see Whyte, 2018; Tombs, 2018). Senior management test was not an issue in the MNS Mining case, since it is difficult to say that police agencies successfully applied senior management test in the MNS Mining Case. It can be observed throughout the court discussion that the court investigation focused on Mr Fyfield's testimony and failings rather than organisational failure. Critical criminologists argue that finding and punishing the responsible actors may be difficult (Forti and Visconti, 2020; Ruggiero, 2015; Tombs and Whyte, 2015). Such criticism is generally based on high-profile cases. However, this research

has found that punishing companies responsible for a negligent act may also be an issue in cases involving small or medium-sized companies.

Likewise, in the Nikolai Valkov case, it cannot be said senior management test was important factor in securing justice even though there were three companies and several managers, as evidence, testimony and agencies can help to find the controlling mind (within company) who is responsible (on behalf of the company) for negligence. The main reason is that the complexity of the companies' structure (Koseoglu Metal Works and Ozdil Investment) was not high compared to a larger organisation. As Tombs (2018) states, Parsons (2018, p.310) indicates that the companies (small or medium size) would be punished 'under the identification doctrine with its 'controlling officers' test (…) therefore, do not illuminate the potential impact of the Act in respect of large organisations'. On the other hand, it cannot be easily said the companies and directors could be punished under identification doctrine considering the number of companies (three) and relatively high number of managers involved in the Nikolai Valkov case.

The findings of these two case studies can be accepted as critical contribution to efficiency of new Act debates in criminology by indicating two issues. One is that punishing corporate violence may still and also be a problem regardless of senior management test as it is observed in the MNS Mining case. This case shows that a small or a medium size company cannot be punished because of various reasons. Other reasons (complexity of the cases, powerful defence team, the low-level performance of agencies) apart from the structure of the Act may lead to failing secure justice in the cases involving small or medium size companies. The critics related to liability in safety crimes made by Parsons (2018) help to understand this problem (see p. 19). Another relevant argument in explaining the result in this kind of case can be found in Pearce and Tombs' (1998) study. They state that the criminal justice system is based on capitalist values and cannot treat fatal workplace accidents as manslaughter or homicide, even though there is no logical reason not to evaluate these cases in this way. The validity of this argument, which refers to the critical criminology's (crimes of the powerful) focusing point, can be observed not only in the MNS Mining case and the number of unpunished cases but also in the low number of not-suspended prison sentences and the high number of lenient fines. However, this case shows us only one face of the complicated treatment of safety crimes. I will discuss this issue further with the findings of Chapters 5 and 8 below.

Second is that the Nikolai Valkov case shows that New Act successfully applied in the cases involving small companies though the case cannot be evaluated an instance to provide insights in evaluating performance of novelty (senior management test) of CMCH Act. Even though there

were two companies and more than four managers, strong evidence and the agencies' approach helped to punish the responsible actors for negligence.

These different prosecution processes suggest that, even though the cases were considered significant by the police and non-police agencies, one, MNS Mining, went unpunished. The study found that two factors – the adequacy of evidence and testimony in convincing the jury to return a guilty verdict; and the specialised knowledge needed to understand the complexity of the case and the additional prosecution processes to explain how the accident happened – played a central role in the final decision. This is another contribution of this thesis to literature: that these two cases show the importance of the agencies' approach to cases in defining WRDs as a crime or accident. For instance, in the first case study (the death of Nikolai Valkov), the circumstance that led to death was considered to be a lack of safety provision rather than failing from height (see Section 6.2.2). However, in some cases police agencies considered natural causes, technical failure or workers' responsibility rather than the negligence of companies or individuals (see the accidental death, no further information on court process and no information crime vignettes).

The safety crime vignettes (see Section 8.2) suggest that it is difficult to say that there are obvious differences in the prosecution process between safety crimes and corporate manslaughter. However, the agencies' policies and approaches, and the boundaries of the acts, are two factors in determining cases as safety crimes rather than corporate manslaughter. These findings are part of the answer to the research questions as they provide insights into the reasons behind not-guilty-of-corporate-manslaughter decisions. Labelling companies' wrongdoing as safety crime can be seen at least as partial justice considering the large number of cases that went unpunished and not investigated. Ultimately, these actions (labelled safety crimes) of companies and individuals are not considered severe enough to deem the action corporate manslaughter. It is widely observed that agencies such as the HSE, police and CPS pay close attention to punished cases, and the joint investigation process is reflected in media reports. This analysis can be seen as an insight into the reasons behind why some cases are not punished as corporate manslaughter.

These findings suggest that the CPS plays a critical role in the court process. For instance, it determines the law and regulations to investigate a case and rarely decides that the conditions are suitable to investigate a case under the CMCH Act, as can be observed from the number of cases prosecuted and investigated under the HSW and CMCH Acts presented in annual statistics.

One of the participants (HSE P1) highlighted this issue:

> ***The HSE remains involved with the case until the conclusion of any enforcement action. If the CPS*** *(author's emphasis) brings a prosecution for corporate manslaughter, it is likely that HSE inspectors will be called as witnesses if they had significant involvement in the investigation. If, as*

> *in the vast majority of cases, the prosecution is brought by the HSE under the Health and Safety at Work etc Act 1974 and associated legislation, we remain involved and bring the prosecution ourselves without involvement from the CPS.*

Tombs and Whyte (2007, p.103) state that:

> It is rarely the case that a failure to prosecute is merely down to insufficient evidence. It is the under-investigation of safety crimes and the lack of resources dedicated to inspection that are the key factors in keeping detection rates low.

This thesis partly agrees with this explanation that 'no information' and 'no further information' vignettes show that many cases failed to be prosecuted because of unsatisfactory evidence (see Sections 8.4.1 and 8.4.2). Nevertheless, the HSE cannot investigate every case thoroughly due to limited resources and time. However, the vignette on the death of Russel Robinson shows that, even though police agencies paid close attention to the case, the prosecution was a failure. The condition of the accident area and lack of witnesses affected the prosecution processes.

Moreover, the main ostensible reason is difficulties in finding satisfactory evidence to convince the jury to return a guilty verdict, as observed in the death of Kevin Dorman (see Chapter 8). Even though the managers in the case (Kevin Dorman) were under suspicion of corporate manslaughter, the jury gave a not guilty decision after investigating the crime scene. The court's role and approach may have contributed to the difficulties that occurred and to not guilty decision being given. For instance, in this case, the agencies focused on a technical failure (the brakes). This thesis suggests that the ostensible reason that led to the death given by the agencies was difficulties in finding sufficient evidence. Additionally, agencies paid attention to technical failures rather than the negligence of companies or managers. This situation can be observed through vignettes analysed (see Sections 8.2.6, 8.5.1).

Several reasons led to these cases going unpunished (and non-investigated). Before discussing these reasons further, it should be noted that the criticism made in the literature review about the limitations of regulations covering illegal and wrongful activities of a corporation (see Friedrichs, 2015; Tombs and Whyte, 2007; Pearce and Tombs, 1998) concurs with the findings of this thesis. A remarkable number of cases (237 out of 754) are out of the scope of corporate criminal law. This thesis partly agrees with Tombs and Whyte (2007, p. 93) that 'if the police are not involved in the investigation of safety crimes, then those crimes are less likely to be socially constructed as "real" crimes.' This can be empirically observed in 'no information' cases (see Figure 9-3). However, there are a remarkable number of cases among 'no further information' cases that, even though the police, sheriff, coroner, and procurator fiscal investigated, these cases went unpunished.

The data gathered from the HSE via an FoI request (22/08/2022) support the accuracy of these factors. The findings from these vignettes can be discussed in terms of their relation to critics' opinions raised in the criminology literature (Galvin, 2020; Hébert, Bittle and Tombs, 2019; Tombs, 2018; Almond and Colover, 2010; Tombs and Whyte 2007; see also Chapter 3). The criticisms relevant to this study relate to the treatment of safety crimes, which can be limited to three issues: (i) the low number of convictions; (ii) the problematic approach taken by police and non-police agencies; and (iii) the reasons leading to WRDs overwhelmingly being seen as technical failures or due to natural causes.

Essentially, agencies prefer to negotiate with companies and other organisations rather than punish them. Crown censure orders, coroner's reports and accidental death decisions show that agencies follow a policing strategy that coincides with the compliance school's arguments (see Gray, 2006; Hawkins, 1990) rather than a punitive policing strategy (see Chapter 3). The analysis of coroner's reports shows that agencies agree that there are failures, and they need to be fixed to prevent workers' deaths. However, these failures have not been evaluated as a crime or violation of regulations, but overwhelmingly as the result of technical failure or a low level of negligence. Coroner's reports and the companies' efforts can be evaluated as a positive attempt to protect workers' lives in the future. However, some repeated accidents in the same industries, which coroner's reports have focused on, show that this strategy has not been very successful (see Slapper, 1993).

Taken together, these reports, the remarkable number of accidental deaths, non-investigated cases, sheriff's reports (that reflect the police's approach to WRDs) and the low number of corporate manslaughter convictions provide insights into understanding regulations strategies as applied by the police and non-police agencies. This research reinforces the impression that governments have taken a lenient approach to corporate offending. Government policy against safety crimes can be evaluated in the light of regulations strategies discussed in the literature review. If we remember the discussion of policing safety crime in the review (see Section 3.4.2), compliance suggests a lenient approach to corporate crimes because companies are not 'amoral calculators' and their self-regulation can be more effective than a punitive approach (see, Gray, 2006; Pearce and Tombs, 1998), while the reintegrative approach claims that a consensus between corporations and agencies can be effective in fighting corporate offending, with court process and severe punishment used as a 'last resort' (see Braithwaite, 1984). Considering the punishments handed down in safety-related corporate-crime cases, it is highly likely that governments have not taken a punitive approach to corporate offending and have maintained a regulations strategy due to the deterrence and compliance approach's arguments and conclusion.

The policing strategy applied here differs from that seen for other crimes. It can be observed that a non-police agency (HSE) has a central role in these cases. This issue is mentioned by Tombs and Whyte (2007), who point out the differences between the policing of safety crimes and street crimes (see Section 3.1.2: Safety crimes). However, apart from these differences there are some similarities considering the prosecution process. For instance, Chapters 5, 6, 7 and 8 show that obvious negligence was proven in court by police and non-police agencies using CCTV records, emails, photos and safety check documents. Subsequently, the gathering of satisfactory evidence and witnesses by these agencies helped secure (partial) justice, which shows the importance of the evidence-collection process and the agencies' role in it. Importantly, the police agencies' role on corporate and safety crimes, the court and jury's approach to the case provide insights about applied punishment (severe or lenient).

As discussed in the literature review, Huisman and Erp (2013) take our attention to the possibility of adopting a prevention strategy for corporate crime similar to that aimed at street-level crime. This approach, situational crime prevention theory, may be applied to workplace corporate offending. The present thesis shows that many cases have gone unpunished and not been prosecuted because of an inadequate evidence collection process (see Chapter 5 and Section 8.4) and the neglect of duties in the workplace by companies. As a result, more frequent safety and security checks and better communication with directly workers may help to reduce workplace corporate offending. However, the necessary increase in personnel and other resources for police and non-police agencies make it unlikely that this will become government policy any time soon.

Problems related to safety crime arise in practice, such as the legal examination of worker deaths under different laws and regulations, and punishments. Statistical analysis shows that many workplace deaths (90 per cent of punished cases) have been treated under health-and-safety acts and regulations, while crime-related institutions evaluate only a small number of cases under corporate criminal law. Simpson (2019) highlighted a critical consequence of this complexity: that some cases are not evaluated under crime-related law; hence actions cannot be categorised as an offence.

This thesis has identified the characteristics of different investigation results in Chapters 5, 6, 7 and 8. The delineation of successful, unsuccessful, and non-prosecuted cases explains (see Section 9.2) why some work-related deaths are evaluated as safety crime while others are not. Chapters 5 and 8 indicate what types of case are conceptualised as an accident rather than a crime. In the introduction chapter (see Section 1.2.1), I set out fundamental arguments and criticisms about conceptualising safety crime as a type of corporate crime. Michalowski (2015) expresses the problematic view that specific types of harm are seen as a crime. The findings empirically show under which conditions a wrongful activity can be perceived as an illegal activity. For instance, if

the deaths happened in the construction or manufacturing industries and there are witnesses, they are worth investigating (HSE's policy relies on the use of time and resources), there is possible negligence by the company (according to the HSE and police) and they can be evaluated as a crime. The vignettes show that some of these cases are seen as a matter of workers' responsibility or the result of contingent factors. It can be observed in the vignette on the death of Ian John Leitch Black that the sheriff considered that 'Mr Black was the author of his own misfortune'. These vignettes also show how theoretical approaches can be observed in practice. In this way, this thesis contributes to this debate (see following criticisms) by showing agencies approaches (considering the reasons led to workers' death as technical failure, natural causes and workers' responsibility) to cases in the prosecution and punishment processes. Many (Galvin, 2020; Hébert, Bittle and Tombs, 2019; Tombs, 2018; Almond and Colover, 2010; Tombs and Whyte 2007) point out that the wrongful activities of companies are seen as a technical failure or due to natural causes rather than as serious crime; they highlight the small number of convictions in the criminal justice system.

These findings allow us to reconsider the criticisms often made by critical criminologists (Tombs and Whyte, 2007; Pearce and Tombs, 1998) that there is no logical reason not to evaluate WRDs as safety crime. It is because some harmful actions are seen as crimes of the powerful that they are not considered crimes by governmental agencies (see Section 3.3: Crimes of the powerful). Scholars have sought the answer in the relationship between policy and the economic system (Bittle et al., 2018; Frauley, 2018; Tombs and Whyte 2007; Pearce, 1976). On the one hand, of course, the findings of this thesis can be read through this theoretical lens (to explain the effect of having a professional defence team, strict guidelines and regulations, agencies' policy and blaming workers for the results of investigations); even to avoid engaging these grand discourses may lead to theoretical limitation. On the other hand, this thesis indicates critical findings may not work with this theoretical approach. The main reason is that I have not focused on high-profile WRDs; most of the cases examined are 'low-level' cases proves one of the key arguments of critical criminology that punished responsible actors are rarely 'powerful. In addition to this, this thesis shows that the criminal justice system takes an inequitable approach not only to large companies and their actions but also to small- and medium-sized businesses.

The factors (difficulties finding evidence, the condition of the crime scene, having a professional defence team, complicated issues etc) mentioned above for the not-guilty decision (see the MNS Mining case, and the 'no information' and accidental death vignette) may provide some possible answers for 'logical reason' even though these findings may not cover the authors' intended aims. In addition, the agencies played important roles in each different result.

Public interest is an important factor in prosecuting a case under criminal law. The agencies (particularly the CPS) consider the public interest in deciding whether a case should be prosecuted under the CMCH Act or health-and-safety law. The CPS (Crown Prosecution Service, 2018) takes public interest into consideration as an important factor 'in securing corporate accountability for serious offending'.

It is highly likely that many prosecutions have failed because CPS prosecutors did not consider there was a public interest in opening a criminal prosecution in these cases. The empirical findings support this argument, in that some cases generally resulted in 'no information' or accidental death due to insufficient evidence. In such cases a conviction is not likely, so CPS prosecutors may not see the public interest; it seems that a discretionary role is taken by the CPS in such cases (Daw, 1989). Tombs and Whyte (2007) considered this factor a 'protective state response' against corporate offending (see Chapter 3).

The findings have enabled a precise analysis of punishments for corporate manslaughter and criminal activities that led to workplace deaths. The issue of punishments for work-related deaths has been illustrated briefly by the statistics (see Figure 5-19). Examples of fines have ranged from £500 (*Manchester Evening News*, 2013) to £5 million (BBC, 2019a). ***Figure 9.4*** shows the inconsistency in meting out justice for the same actions that have caused the same harm. Accordingly, a company's size is not an important factor in determining a guilty or not guilty verdict; every company can be punished and prosecuted, regardless of its size. Although the courts punish a large company with an appropriately large fine, the majority of companies that receive punishments are small enterprises. However, when the courts consider imposing a penalty for criminal activities, they pay attention to whether the company will continue to operate and its contribution to the economy. It is difficult to say that having a poor safety record is not sufficient grounds to prove a company's illegal activities are corporate manslaughter. This shows that company size may only be a factor in determining the amount of penalty handed down, not in determining whether it is punished.

Workplace corporate offending is punished most often with fines and occasionally with prison sentences (though these are mostly suspended). Imposing so few prison sentences for corporate crime is criticised by many in the literature (Galvin, 2020; Campbell, 2019; Reiman, 2007). This reality again represents one of the characteristics of the crimes of the powerful (see Section 3.3). The courts rarely hand down the three other types of possible penalty: (i) compensation; (ii) publicity; or (iii) community sentence. A statistical analysis of work-related deaths indicates that the orders can be made public, as in the case of Jason Pennington (see Chapter 5).

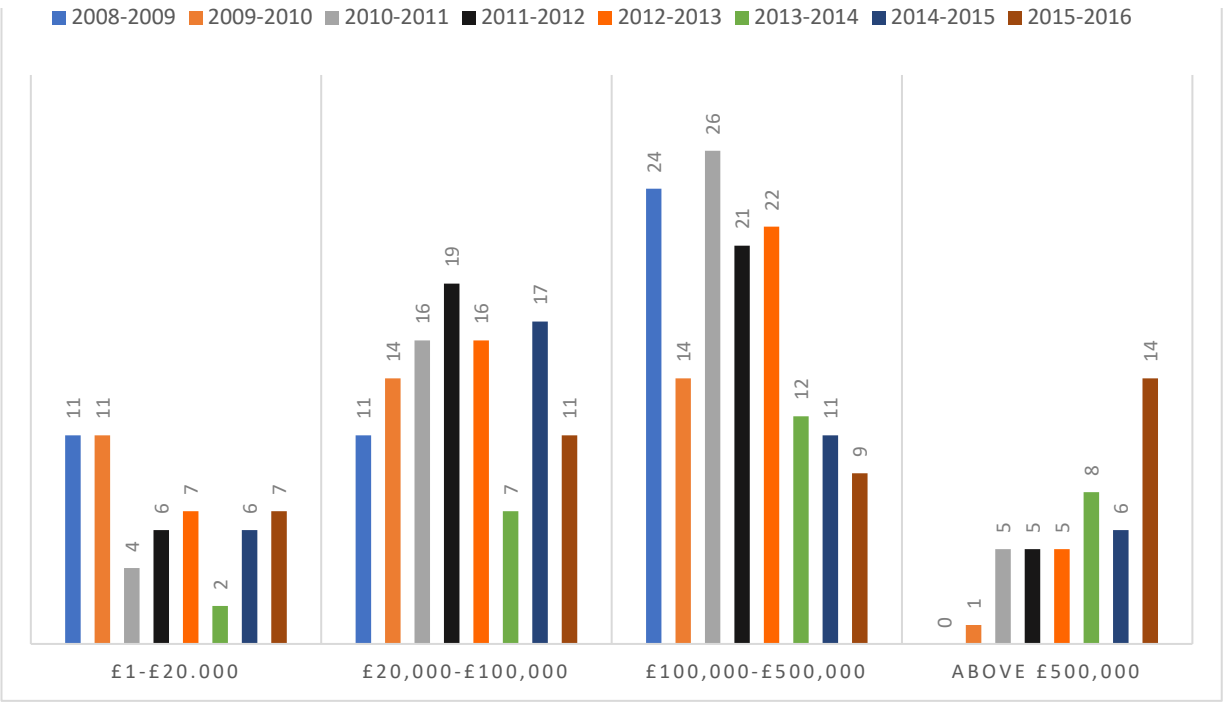



*Figure 9-4 The values of fines (2008-2016)*

In ***Figure 9.4*** there is a clear increasing trend in fines above £500,000. The table illustrates that more cases involved fines of £500,000 and above after the period 2010-2011. On the other hand, there has been a gradual decrease in fines between £100,000 and £500,000 since 2012-2013. There was a distinct difference in punishments in the periods 2013-2014 and 2014-2015 which is evident in ***Figure 9.4***. Additionally, the graph tells us that police agencies do not generally impose severe fines, as can be observed in the small number of penalties above £500,000. One of reasons for this is that the number of researched cases is lower than in other years (see Table 9.1).

*Table 9-1 Number of researched cases by year*

| Years | Researched cases in numbers |
|---|---|
| 2008-2009 | 104 |
| 2009-2010 | 89 |
| 2010-2011 | 107 |
| 2011-2012 | 105 |
| 2012-2013 | 90 |
| 2013-2014 | 79 |
| 2014-2015 | 82 |
| 2015-2016 | 98 |

Another reason is that new sentencing guidelines covering corporate manslaughter, health and safety, and food-safety offences came into force on 1 February 2016. These allowed the courts to impose higher fines and gave them greater authority over companies and individuals.

There was only one period (2015-2016) that the number of cases involving fines above £500,000 was higher than the number of cases where fines between £100,000 and £500,000 were imposed. Additionally, a remarkable number of cases (54) was concluded with fines less than £20,001. This picture provides insights into the seriousness of corporate crime that it is difficult to say that the criminal justice system seriously perceived corporate offending in the UK. As mentioned in the literature review, Slapper (2010) highlighted that there is a strong relationship between the amount of the fine and the seriousness of crime.

Regardless of the size of the company, statistical analysis (Chapter 5) shows there have been many small companies involved in cases in which workers have died. As distinct from the CoP framework (see Chapter 3), this shows that the problematic picture of punishment is not only associated with large organisations. Moreover, 'no information' and accidental death cases indicate that some small companies and their managers have not been punished. However, contrary instances can be found - for instance, the MNS Mining company was not punished while Koseoglu Metal Works was (it was smaller than MNS Mining).

Tombs and Whyte (2007, p.100) make a critical point that helps understanding of the agencies' policies in the prosecution process of WRDs:

> **The way that safety crimes are processed before they are considered for prosecution is crucial to understanding the rates of prosecution.** Regulators generally do not investigate or respond formally to all breaches of the law. Just as when a crime is reported to the police, at some point there will be a decision taken by the regulator about whether a reported incident is worth taking action over or not.

Chapter 5 exemplifies this situation by analysing some features of no information cases and indicating particular sectors (such as transport and agriculture) in which these cases happened. It should be noted that Chapter 5 indicates the importance of these cases via numbers which occupy a relatively important place within varieties of investigation. This helps to reify safety crime. Indeed, I believe that one of the most important contributions of this thesis is in reifying safety crime via numbers. This thesis indicates rates of prosecution, conviction and more (see Chapter 5) as precisely as possible and finds that this explanation (see the explanation given above; Tombs and Whyte, 2007, p.100) is still valid after 15 years, leading to the prosecution process of a remarkable number of cases being closed before they are heard in court. This thesis contributes to this debate in two ways. First, Chapter 5 indicates the number of unpunished and

not prosecuted cases which gives a precise prosecution and conviction rate (as far as is possible) and we know number by number and name by name which cases have been unpunished and went not prosecuted. The second contribution is that the characteristics of these types of prosecution process are identified in Chapter 5 and broadly in Chapter 8 via crime vignettes (see 8.4).

As discussed in the Introduction, the definition of corporate crime should be reconsidered. To fulfil this objective, this thesis suggests some issues that should be considered in the definition of corporate crime by drawing on Croall's (2001) proposal (see Chapter 1) and the findings of this thesis that a working definition should: (i) cover small companies and their managers' negligence; (ii) be clear about the definition of negligence and cover even a low level of negligence such as not determining alternative emergency plans at work; and (iii) consider the irresponsible actions of companies and individuals as serious negligence regardless of the agencies' approach and policy.

## 9.3 Implications of this study and future research

This thesis suggests that the government reconsider the structure of the Health and Safety Executive. I have shown that the most important agency is the HSE, even though it has the weakest legal power. The HSE should be empowered like a police force. Resources such as the number of staff and budget of the HSE should be increased accordingly. This would help change many things, such as the perception of safety crime, and conviction and prosecution rates. Importantly, a more powerful HSE could contribute to securing justice in safety crime.

This thesis finds that, in the cases studied, the criminal justice system applied various acts and regulations. If the prosecution and punishment of workplace deaths were to be evaluated under a unique law, the complexity of this problem would be eliminated, and justice could be delivered more powerfully and fairly. This can be applied in two ways: corporate manslaughter law can replace all health-and-safety regulations and acts. Secondly, corporate criminal law and health-and-safety regulation can be combined, and new legislation generated.

This study recommends that agencies (CPS, police and HSE) work together to create a reliable official database of safety and corporate crimes. Accordingly, these weaknesses (see Challenges and limitations) allow me to suggest some further research projects. Initially, a digital database could be generated as a follow-up research project, covering key information such as the name of the court, punishment type, date of hearing, result of case and the name of the effective agency. Even though there are some sources (HSE's conviction case list, Lexis, Judiciary) these do not constitute a whole and reliable database. This leaves a strong need for a reliable source to reify the safety crime problem in the UK; the resource would be very useful for corporate crime

researchers in the future. Another important study that relied on fieldwork data gathered from police and non-police agencies would be useful. This would make an important contribution to the literature by researching the decision-making process of agencies in the prosecution and punishment processes.

Lastly, the current study could be enhanced by extending the period and number of cases under study in ways that conditions prevented me from doing, notably by including deaths of self-employed people and members of the public.

## 9.4 Final remarks

In the cases studied, many WRDs were not seen as corporate manslaughter for particular reasons. In some cases, the prosecution process was completed before the case was sent to court. This is evident in the 'no information' and 'no further information on court process' cases. 46 per cent of cases were punished under health-and-safety laws and regulations between 2008 and 2016. The CPS and court preferred a charge of gross negligence manslaughter in only 11 cases, and only 3 per cent of cases resulted in corporate manslaughter. 16 per cent of cases resulted in accidental death due to many factors including the policing of safety crime.
The policing of safety crime is critical in explaining work-related corporate offending in the UK. Even though the weakest agency in terms of its legal power is the HSE, it plays a pivotal role in securing (or not securing) justice. Structural problems (the content of the act, the intention of agencies to evaluate a case as corporate manslaughter and government policy on policing safety crime) indirectly but significantly affect the current corporate manslaughter problem in the UK. The level of seriousness of corporate manslaughter is higher than other safety crimes (convicted cases under health and safety regulations) for police and non-police agencies.

UK government policy and legislation concerning safety crimes have been implemented in various complicated ways. This highlights the importance of the analysis, which covers different types of prosecution and punishment processes to interrogate the rationales underpinning agencies' final decisions and the factors that are effective in terms of different verdicts and to elucidate a problematic picture of the criminal justice system:

- The criminal justice system has taken a lenient regulatory approach, which can be seen in accidental death verdicts, coroner's reports, the low conviction rate, fines very small to act as a deterrent and the HSE's and CPS's policies.

- Three important approaches within the prosecution and punishment processes are effectively part of the problematic picture of safety crime as a type of corporate crime, namely *satisfactory evidence, agencies' approach and role (such as deciding public interest in a case and prioritising deaths in particular industry sectors) and the seriousness of negligence*.
- Many WRDs are found to be due to technical failures, natural reasons or workers' failures.

# *Appendix A Example of Consent Form*

## CONSENT FORM

**Study title**: The investigation and court process of corporate wrongdoing in England and Wales: Multiple Case Studies.

**Researcher name**: Cem Ozdemir

**ERGO number**: 55677 *(Approved by 11/06/2020)* [30/11/2020] [Version Number 7]

Participant Identification Number (if applicable*):*

***Please initial the box(es) if you agree with the statement(s):***

| | |
|---|---|
| I have read and understood the information sheet (30/11/2020*/version no.7 of participant information sheet)* and have had the opportunity to ask questions about the study. | |
| I agree to take part in this research project and agree for my data to be used for the purpose of this study. | |
| I understand my participation is voluntary and I may withdraw (up to 6 months after the interview) for any reason without my participation rights being affected. | |
| **Please initial only ONE of the boxes if you agree with the statements:** | |
| I consent to have all my personal details and responses identified personally with me in reports of the research, dissertation and related publications such as journal papers. | |
| I consent to have statements used as I articulated them without disclosing my personal details. | |
| I would like all my personal details and statements to be anonymised and excluded from the final thesis made public as well as related publications. However, I realise | |

| | |
|---|---|
| that others might identify me based on the data, even though my personal details will not be revealed. | |

Name of participant (print name) ……

Signature of participant……

Date……

Name of the researcher (print name) ……

Signature of researcher ……

Date……

# *Appendix B Example of Participant Information Sheet*

**Participant Information Sheet**

***[30/11/2020] [Version number 7]***

*(Approved by 30/11/2020)*

**Study Title**: The investigation and court process of corporate wrongdoing in England and Wales: Multiple Case Studies.

**Researcher**: Cem Ozdemir **ERGO number: 55677**

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is essential that you understand why the research is being done and what it will involve. Please read the information below carefully before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether to take part. If you are happy to participate, you will be asked to sign a consent form.

**What is the research about?**

This study aims to explore the investigative and court process of corporate wrongdoing in England and Wales in the light of multiple case studies. The individuals and organisations were evaluated under different laws and regulations. I will conduct semi-structured interviews with people who are involved in these kinds of cases as well as people who have knowledge and experience about prosecution and court process of fatal workplace injuries: the owners of the companies, the lawyers of the companies, the police, the members of the Crown Prosecution Service (CPS), and the members of Health and Safety Executive (HSE), solicitors and experts to understand the investigative and court process of the fatal workplace injuries regarding their experience and approach. I am not interested in anything beyond the process of the cases.

**Why have I been asked to participate?**

You have been chosen for this research because I would like to benefit from your valuable experience and knowledge of the case.

**What will happen to me if I take part?**

If you are suitable for the study, the interview will be arranged at a time and place that is convenient to you. If the interview will be done by email, you will receive interview questions via SafeSend which is a platform for sending secure emails. The interview is likely to take 45 - 60 minutes.

The researcher will either meet with you in person at a mutually convenient location or virtually through one of following options: Teams, Facebook, Zoom and Skype, or email. You will be asked questions about your knowledge and experience. For those who will be interviewed online, consent questions will be read out and verbal consent will be audio-recorded and stored securely. Alternatively, you will be asked to sign the consent form

before the interview. You can receive the consent form and post-interview form by SafeSend mode of e-mail or post. You need to sign consent form electronically and send it to researcher via email or by post.

For those, who will be interviewed face-to-face, written informed consent will be obtained prior to participating the study during the interview visit. The interviews will be audio recorded depending on your choice and transcribed verbatim. For those who will be interviewed via email, you will receive semi-structured interview questions via SafeSend. In this case, you need to answer questions and send them to the researcher through email. You will also receive the Consent Form via email. You can sign Consent Form electronically and send signed Consent Form to researcher via email.

If you would rather not be audio-recorded, notes will be taken in written form by the researcher who will transcribe them. It is likely that you will be interviewed only one, but further conversations may be negotiated.

Once the interview is complete, the researcher will ask you to fill in the Post-Interview Form to determine how your responses will be used in the dissertation. If you choose to be interviewed online or by email, you can fill the Post-Interview Form and send it to the researcher by e-mail or post. Alternatively, you can fill the Post-Interview Form with researcher through online or email conversations.

If you choose to be interviewed face-to-face, you can fill the Post-Interview Form by hand after the interview.

**Are there any benefits in my taking part?**

There will not be any individual benefit, but you will be contributing to the researcher's study and shedding light on an important issue.

**Are there any risks involved?**

The research does not have any risks.

**What data will be collected?**

Only data related to the research topic will be collected. Data collected will focus on your experience and knowledge related to workplace fatal injuries regarding investigative and court processes. Your personal information will be kept confidential and securely kept in encrypted files which only the research team has the right to access. The data will be collected by the researcher from candidates via face to face or online interviews. If the data collected is related to personal information, you will be informed and given options by the researcher about the ways in which this data will be used. The personal information will not be used by the researcher in the research report and dissertation unless you provide specific consent. If you provide specific consent to the use of your details, the researcher can use your personal details such as name and status in dissertation and reports.

**Will my participation be confidential?**

Your participation and the information we collect about you during the research will be kept strictly confidential as much as possible. Some parts of your interview may be described in study reports and dissertation. However, if you were known publicly in

research papers and news reports, it is possible that the researcher may not fully guarantee your anonymity.

However, the researcher will take several precautions to sustain maximum confidentiality by the implementation of measures such as using aliases/codes instead of your name and avoiding direct interview quotes. You will be given three options in the Consent Form concerning disclosure offering varying degree of anonymisation, and the researcher will use your data accordingly in the final research report. These options include:

1. You may allow the researcher to use your responses and personal characteristics such as your occupation in the final research reports. If you choose this option, you will be identified in the research reports. You can be publicly tracked in the dissertation and any subsequent research. This option allows the researcher to use your identifiers such as name and job in the research documents.

2. You may allow the researcher to use part/parts of your speech without mentioning your name, status, or occupation. Direct identifiers such as your name, job title and location will not be mentioned in the study. The researcher will provide you with a significant level of anonymity and confidentiality. The researcher will use codes such as “participant 1” while using your responses in the reports of the dissertation and any related publications.

3. Lastly, you may choose to have both your identifiable information and interview quotes redacted from the final public study reports. This option provides the higher-level anonymity achievable for you in this research. If you choose this option, every step will be taken to preserve your anonymity. The researcher will give assign you specific codes such as “participant 1” so that the reader will not able to trace your information back to you. Additionally, an assurance of anonymity will be sustained by excluding direct quotations from the final thesis and any related publications. In this case, your statements will be placed into an appendix at the end of the thesis, which will be restricted from public view.

If even one of the participants who involved the same case does not allow the researcher to use their identifiers such as name and job, the researcher will not use any of the participants' identifiers who involved the same case.

Furthermore, you will be asked to fill out a Post-Interview Form. In this form, you may consider and decide how your responses will be used in the research reports and any related publications depending on your choice.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

The digital/digitalised data will be kept electronically in a password-protected computer. The collected data will also be taking place on my online storage drive of the University of

Southampton, which only the researcher can access via secured password. The printed data will also be kept locked in a bag. This locked bag will be stored in a locked drawer to guard against the risk of theft. The data, password and the key will not be shared with any other person. After the study, disposal and destruction of all printed data and audio recordings will be undertaken using the University's Recommended Practices for Destruction of Data.

**Do I have to take part?**

No, it is totally up to your choice whether to take part or not. If you decide to be interviewed, you will need to sign a consent form to show you have agreed to be part of this research.

**What happens if I change my mind?**

You have the right to change your mind and withdraw at any stage of the interview without giving a reason. You also have the right to change your mind and withdraw up to 6 months after the interview. Your data will be destroyed securely if you wish to withdraw from the study within this time frame. It will not be possible to remove your data from the study If you decide to withdraw after this time period.

**What will happen to the results of the research?**

Your personal details will remain strictly confidential. Depending on your request which is stated in the consent form, research findings may or may not include information that can directly identify you. After the interview, the researcher will ask you to fill out the Post-Interview Form that will determine how your responses will be used in this study. Your responses will be used according to your requests in the Consent Form and Post-interview Form.

If you have a concern, you can get information from the researcher, whose contact details are shown below.

Cem Ozdemir

Phone : +44 (0) 785 241 29 70 E-mail : co1a17@soton.ac.uk

Primary Supervisor: Professor Jenny Fleming E-mail: j.fleming@soton.ac.uk

Head of Department, Sociology, Social Policy and Criminology

The University of Southampton.

Economic, Social and Political Science

Southampton SO17 1BJ.

**Where can I get more information?**

You can also raise any questions with my supervisory team, whose contact details are shown below:

**Professor Jenny Fleming** **Professor Rod Rhodes**

**Professor Jenny Fleming**
Head of Department, Sociology
Social Policy and Criminology
The University of Southampton.
Economic, Social and Political Sciences
Southampton SO17 1BJ,
E-mail: *j.fleming@soton.ac.uk*

**Professor Rod Rhodes**
Politics and International Relations
Economic, Social and Political Sciences
University of Southampton
E-mail: R.A.W.Rhodes@soton.ac.uk

**What happens if there is a problem?**

If you have a concern about any aspect of this study, you can speak to the supervisors in the first instance and/or:

Head of Research Governance

University of Southampton

Phone : +44 (0) 238 059 50 58 E-Mail : rgoinfo@soton.ac.uk

**Data Protection Privacy Notice**

The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University has to ensure that it is in the public interest when we use personally identifiable information about people who have agreed to take part in the research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly,

it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal Data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

**Thank you for taking the time to read the information sheet and considering taking part in the research.**

# *Appendix C Example of Post-Interview Form*

## POST-INTERVIEW FORM

***[30/11/2020] [Version Number 2]***

*(Approved by 30/11/2020)*

**Study title**: The investigative and the court process of corporate wrongdoing in England and Wales: Multiple Case Studies.

**Researcher name**: Cem Ozdemir

**ERGO number**: 55677

Participant Identification Number (if applicable*):*

***It is our aim and responsibility to use the information that you have shared responsibly. Now that you have finished the conversation, we would like to give you the opportunity to provide us with additional feedback on how you prefer to have your data used.***

***Please initial only one box if you agree with the statement(s):***

| | |
|---|---|
| You may share the information just as I provided it. No details need to be changed and you may use my real name when using my data in publications or presentations | |
| You may share the information just as I provided it; however, please do not use my real name. I realize that others might identify me based on the data, even though my name will not be used. | |
| You may share the information I provided; however, please do not use my real name and please change details that might make me identifiable to others. In particular, it is my wish that the following specific pieces of my data not be shared without first altering the data so as to make me unidentifiable (describe this data in the space below):----------<br>----------<br>----------<br>---------- | |

Name of participant (print name) ……

Signature of participant……

Date……

Name of the researcher (print name) .....

Signature of researcher .....

Date.....

# *Bibliography*


Almond, P. (2008) 'Public Perceptions of Work-Related Fatality Cases: Reaching the Outer Limits of "Populist Punitiveness"?', *British Journal of Criminology*, 48(4): 448–67.

Almond, P. (2009) 'Understanding the seriousness of corporate crime: Some lessons for the new 'corporate manslaughter' offence', *Criminology and Criminal Justice System*, 9(2), pp. 145-164.

Almond, P. (2013) *Corporate Manslaughter and Regulatory Reform. Crime Prevention and Security Management*. Basingstoke: Palgrave Macmillan.

Almond, P. and Colover, S. (2010) 'Mediating Punitiveness: Understanding Public Attitudes towards Work-Related Fatality Cases', *European Journal of Criminology*, 7(5), pp. 323–338.

Almond, P. and Colover, S. (2012) 'Communication and Social Regulation: The Criminalization of Work-Related Death', *British Journal of Criminology*, 52(5), pp. 997–1016.

Anderson, R. (2012) *Inquiry Under the Fatal Accidents and Inquiries (Scotland) Act 1976 into The Sudden Death of James Steele*. (2012FAI 29). Available at: https://www.scotcourts.gov.uk/search-judgments/judgment?id=f37f86a6-8980-69d2-b500-ff0000d74aa7 (Accessed: 15 November 2021).

Applebey, L. (2015) *£200k fine, suspended sentence and publicity order following safety breaches*. Available at: https://www.shponline.co.uk/working-at-height/200k-fine-suspended-sentence-publicity-order-following-safety-breaches/ (Accessed 5 September 2020).

Arewa, A.O. et al. (2018) 'Analysis of penalties imposed on organisations for breaching safety and Health Regulations in the United Kingdom', *Safety and Health at Work*, 9(4), pp. 388–397. Available at: https://doi.org/10.1016/j.shaw.2018.01.004.

Aujla, W. (2020) 'Using a Vignette in Qualitative Research to Explore Police Perspectives of a Sensitive Topic: "Honor"-Based Crimes and Forced Marriages', *International Journal of Qualitative Methods*, 19, pp.1–10.

Avery, T. (2021) 'We understand that this is not what families had hoped for': Police respond to Bosley Mill trial conclusion. Available at: https://congleton.nub.news/n/39we-understand-that-this-is-not-what-families-had-hoped-for39-police-respond-to-bosley-mill-conclusion (Accessed: 1 January 2022).

Baer, M. H. (2019) 'Propping up corporate crime with corporate character'. *Iowa Law Review*. 10, p. 88–99.

Baldwin, J. (2000) 'Research on the Criminal Courts'. In: R. D. King and E. Wincup, eds. *Doing Research on Crime and Justice*. New York: Oxford University of Press, pp. 375-399.

Barak, G. (2017) *Unchecked Corporate Power Why the Crimes of Multinational Corporations Are Routinized Away and What We Can Do About It*. New York: Routledge.

Barett, F. (2016) 'Winsford company director jailed after worker was crushed to death', *Cheshire Live*, 2 September. Available at: https://www.cheshire-live.co.uk/news/chester-cheshire-news/winsford-company-director-jailed-after-11830648 (Accessed: 7 June 2021).

BBC. (2009) *Cliff fall death driver 'a hero*. Available at: http://news.bbc.co.uk/1/hi/england/bristol/7926120.stm (Accessed: 12 May 2021).

BBC. (2010a) *Inquest opens into tree-fall death of Green councillor*. Available at: http://news.bbc.co.uk/1/hi/england/leicestershire/8683976.stm (Accessed: 7 August 2016).

BBC, (2010b) *No criminal charges after death at Llanelli steel firm*. Available at: https://www.bbc.co.uk/news/uk-wales-south-west-wales-11287833 (Accessed: 28 June 2020).

BBC. (2012a) *Denis Livesley unlawful death verdict overturned*. Available at: https://www.bbc.co.uk/news/uk-england-manchester-19912096 (Accessed: 12 January 2021).

BBC. (2012b) *Apex Scaffolding Services fined over fall death*. Available at: https://www.bbc.co.uk/news/uk-england-sussex-18238886 (Accessed: 23 January 2020).

BBC. (2013a) *Esso fined £100,000 over Fawley sailor death*. Available at: https://www.bbc.co.uk/news/uk-england-hampshire-25412412 (Accessed: 18 December 2020).

BBC. (2013b) *Man jailed after Swan Hunter shipyard death*. Available at: https://www.bbc.co.uk/news/uk-england-tyne-22615868 (Accessed: 15 December 2020).

BBC. (2013c) *J Murray and Sons fined over employee's death*. Available at: https://www.bbc.co.uk/news/uk-northern-ireland-24539809 (Accessed: 15 June 2022).

BBC. (2013d) *Worker hit by car 'collecting road signs' on A24 named.* Available at: https://www.bbc.co.uk/news/uk-england-sussex-23709821 (Accessed: 25 June 2021).

BBC. (2014a) *Barn roof fall death: Man admits safety breach*. Available at: https://www.bbc.co.uk/news/uk-england-oxfordshire-26532499 (Accessed: 23 May 2020).

BBC. (2014b) *Callum Osborne trench death accidental*, inquest jury decides. Available at: https://www.bbc.co.uk/news/uk-england-sussex-29619423 (Accessed: 23 May 2020).

BBC. (2015a) *Wolverhampton engineer killed by car named as Matthew Harding*. Available at: https://www.bbc.co.uk/news/uk-england-birmingham-33648403 (Accessed: 7 May 2020).

BBC. (2015b) *Chevron oil refinery blast: No manslaughter charges*. Available at: https://www.bbc.co.uk/news/uk-wales-south-west-wales-34795830 (Accessed: 10 August 2020).

BBC. (2015c) *George Falder inquest: Pirelli oven death 'accidental'*. Available at: https://www.bbc.co.uk/news/uk-england-cumbria-25369338 (Accessed by: 10 August 2020).

BBC. (2015d) *Total UK fined £1.4m for Lindsey Oil Refinery death*. Available at: https://www.bbc.co.uk/news/uk-england-humber-33709539 (Accessed: 11 August 2020).

BBC. (2015e) *Navy engineer Neal Edmonds asphyxiated on HMS Bulwark*. Available at: https://www.bbc.co.uk/news/uk-england-devon-34479388 (Accessed: 20 December 2019).

BBC. (2016a) *London building firm fined £550,000 after friends fell to their deaths*. Available at: https://www.bbc.co.uk/news/uk-england-london-36642051 (Accessed: 3 May 2023).

BBC. (2016b) *Boss of Utterly Gutterley jailed over ladder fall death*. Available at: https://www.bbc.co.uk/news/uk-england-devon-37660043 (Accessed: 7 May 2020).

BBC. (2017a) *Three jailed for Ben Edge roof fall death in Ramsbottom*. Available at: https://www.bbc.co.uk/news/uk-england-manchester-39294384 (Accessed: 11 June 2021).

BBC. (2017b) *Birmingham company fined over machine crush death*. Available at: https://www.bbc.co.uk/news/uk-england-birmingham-41820850 (Accessed: 10 June 2021).

BBC. (2017c) *Plevin recycling firm to pay £250,000 after man's death fall from lorry.* Available at: https://www.bbc.co.uk/news/uk-england-south-yorkshire-41967999 (Accessed: 20 January 2020).

BBC. (2017d) Boss jailed over Knightsbridge balcony fall deaths. Available at: https://www.bbc.co.uk/news/uk-england-london-40531134 (Accessed: 11 June 2021).

BBC. (2018a) *Tata Steel fined £450,000 for worker's fall into a pit.* Available at: https://www.bbc.co.uk/news/uk-england-south-yorkshire-45400484 (Accessed 9 August 2020).

BBC. (2018b) *Yorkshire Water fined £733k over Mick Jennings fire death*. Available at: https://www.bbc.co.uk/news/uk-england-york-north-yorkshire-45567026 (Accessed: 10 February 2021).

BBC. (2019a) *The story behind the 'tragic' deaths of four workers*. Available at: https://www.bbc.co.uk/news/uk-wales-48539673 (Accessed: 15 February 2021).

BBC. (2019b) *Durham recycling worker Simon Hogg's death an accident*. Available at: https://www.bbc.co.uk/news/uk-england-tees-46987393 (Accessed: 15 February 2020).

BBC. (2021) *Bosley mill blast: Devastation 'like out of the movies'*. Available at: https://www.bbc.co.uk/news/uk-england-55733085 (Accessed by: 15 February 2022).

BBC. (2021b) *Stone grave Aggregates fined £200k over worker death*. Available at: https://www.bbc.co.uk/news/uk-england-tees-56241036 (Accessed: 15 February 2022).

Benson, M. L., Kennedy, J. and Logan, M. (2016) 'White-Collar and Corporate Crime'. In: B. M. Huebner and T. S. Bynum, eds. *The Handbook of Measurement Issues in Criminology and Criminal Justic*e. Chichester: John Wiley and Sons, Ltd, pp. 92-110.

Bittle, S., Sinder, L., Tombs, S. and Whyte, D. (2018) 'Revisiting Crimes of the Powerful An introduction'. In: S. Bittle, L. Sinder, S. Tombs and D. Whyte, eds. *Revisiting Crimes of the Powerful Marxism, Crime and Deviance*. Abingdon, Oxon: Routledge, p. xxxiii.

Bloor, M. and Wood, F. (2008) *Keywords in Qualitative Methods: A Vocabulary of Research Concepts*. London: Sage Publications.

Bohnsack, R. (2010) 'Documentary method group discussions'. In: R. Bohnsack, N. Pfaff and W. Weller, eds. *Qualitative Analysis and Documentary Method in International Educational Research*. Opladen: Barbara Budrich, pp. 99-124.

Bowen, Glenn A. (2009) 'Document Analysis as a Qualitative Research Method'. *Qualitative Research Journal*, 9(2), pp. 27-40. Doi: 10.3316/QRJ0902027.

Bowie,V. (2002) *Workplace Violence*, New South Wales: Workcover.

Box, S. (1983) *Power, Crime, And Mystification*, London: Routledge.

Braithwaite, J. (1984) *Corporate Crime in the Pharmaceutical Industry*. London: Routledge and Kegan, Paul.

Braithwaite, J. (2000) 'The New Regulatory State and The Transformation of Criminology', *British Journal of Criminology*, 40(2), pp. 222-238.

Brown, L. (2017) *Regulation 28: Report to Prevent Future Deaths Report, David Alexander*, Exeter and Great Devon Coroner Court, Judiciary https://www.judiciary.uk/publications/david-alexander/ (Accessed: 15 March 2021).

Bryman, A. (2012) *Social Research Method*. 4th ed. New York: Oxford University Press.

Buchan, R. (2014) *Diver's family stunned by FAI findings*. Available at: https://www.energyvoice.com/oilandgas/60496/divers-family-stunned-fai-findings/ (Accessed: 23 March 2021).

Budd, T. (1999) *Violence at Work: Findings from the British Crime Survey*, London: Home Office/Health and Safety Executive.

Caissie, L.T., Goggin, C. and Best, L.A. (2017) 'Graphs, tables, and scientific illustrations: Visualisation as the science of seeing gerontology', *Canadian Journal on Aging / La Revue canadienne du vieillissement*, 36(4), pp. 536–548. Available at: https://doi.org/10.1017/s0714980817000447.

Campbell, L. (2019) 'Trying Corporations: Why not Prosecute?', *Current Issues in Criminal Justice*, 31(2), pp. 269-291.

Carrabine, E., Cox, P., Fussey, P., Hobbs, D., South, N. and Thiel, D. (2014) *Criminology: A Sociological Introduction* .3rd Ed. Routledge, Taylor and Francis Group. ISBN 978-0-415-64080-0.

Case, P. (2015) 'Tragic tractor driver had 'a love for farming'. *Farmers Weekly*, 15 July. Available at: https://www.fwi.co.uk/business/business-management/health-and-safety/tragic-tractor-driver-love-farming (Accessed:12 January 2021).

Castleberry, A. and Nolenb, A. (2018) 'Thematic analysis of qualitative research data: Is it as easy as it sounds?', *Currents in Pharmacy Teaching and Learning*, 10(6) pp. 1-9.

Channel 4. (2014) 'Gleision mining disaster: manager cleared of manslaughter'. Available at: https://www.channel4.com/news/gleision-mine-accident-wales-malcolm-fyfield-cleared (Accessed: 09 March 2020).

Cheshire Live. (2016) 'Winsford company director loses bid to reduce jail term'. Available at: https://www.cheshire-live.co.uk/news/chester-cheshire-news/winsford-company-director-loses-bid-12085681 (Accessed: 09 July 2021).

Companies House. (2019) *KOSEOGLU METAL WORK LIMITED*. Available at: https://beta.companieshouse.gov.uk/company/07886925 (Accessed: 9 July 2020).

Companies House. (2020a) *OZDIL INVESTMENTS LIMITED*. Available at https://beta.companieshouse.gov.uk/company/06958103/filing-history (Accessed: 10 July 2020).

Companies House. (2020b) *MNS MINING LIMITED*. Available at: https://find-and-update.company-information.service.gov.uk/company/06972004 (Accessed: 4 April 2020).

Corporate Manslaughter and Corporate Homicide Act 2007, c.19. Available at https://www.legislation.gov.uk/ukpga/2007/19/contents (Accessed: 20 August 2020).

Court Reporter. (2019) *Death of Newton Poppleford farm worker in tractor crash was 'unnecessary and caused by gross negligence', court hear*. Available at: https://www.sidmouthherald.co.uk/news/kevin-dorman-tractor-crash-trial-6151720 (Accessed: 12 January 2021).

Cowan, Sheriff Anella M. (2014) *Inquiry Under the Fatal Accidents and Inquiries (Scotland) Act 1976 into The Sudden Death of Russell Robinson*. (2014FAI39). Scottish Courts and Tribunals. Available at: https://www.scotcourts.gov.uk/search-judgments/judgment?id=e1e4bba6-8980-69d2-b500-ff0000d74aa7 (Accessed: 6 June 2021).

CQMS. (2020) *Traffic marshall fatally injured after being struck by a reversing lorry*. Available at: https://cqms-ltd.co.uk/traffic-marshall-fatally-injured-after-being-struck-by-a-reversing-lorry/ (Accessed: 2 January 2022).

Creswell, J. (2014) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 4th ed. London: SAGE.

Criger, D. W. (2011) 'Critical Perspectives on Crime and Social Harm: Toward a Criminology of Human Rights', *Sociology Compass*, 5(11), pp. 984-994.

Croall, H. (1989) 'WHO IS THE WHITE-COLLAR CRIMINAL?', *British Journal of Criminology*, 29(2), pp. 157-174.

Croall, H. (2001) *Understanding white collar crime*. Buckingham: Open University Press.

Croall, H. (2003) 'Combating financial crime: regulatory versus crime control approaches', *Journal of Financial Crime*, 11(1), pp. 45-55. Available at: https://doi.org/10.1108/13590790410809031.

Crown Prosecution Service, (2018) *Corporate Manslaughter*. Available at: https://www.cps.gov.uk/legal-guidance/corporate-manslaughter (Accessed: 7 March 2021).

CPS. Freedom of Information Request, Reference No: 11063, C Ozdemir, 14 March 2023.

Daily Echo. (2015) 'The family of Tony Ockwell say life will never be the same again following his death from a fall from a roof in Ringwood'. *Southern Daily Echo*, 31 October. Available at: https://www.dailyecho.co.uk/news/13928020.the-family-of-tony-ockwell-say-life-will-never-be-the-same-again-following-his-death-from-a-fall-from-a-roof-in-ringwood/ (Accessed:1 January 2021).

Daily Mail. (2009) 'Hero JCB driver died in 60ft clifftop plunge 'to save other drivers', *Mail Online*, 6 March. Available at: https://www.dailymail.co.uk/news/article-1159925/Hero-JCB-driver-died-60ft-clifftop-plunge-save-drivers.html (Accessed : 9 February 2021).

Daily Record. (2013) 'Manager of Welsh pit where four miners died charged with manslaughter', *Daily Record*, 18 January. Available at: https://www.dailyrecord.co.uk/news/uk-world-news/welsh-mine-manager-charged-with-manslaughter-1543495 (Accessed: 5 January 2020).

Davies, E. (2015) *Defective' overhead barrier caused death of Argos lorry driver in Oswestry*. Available at: https://www.bordercountiesadvertizer.co.uk/news/15853052.defective-overhead-barrier-caused-death-of-argos-lorry-driver-in-oswestry-inquest-hears/ (Accessed 5 July 2021).

Daw. Roger K. K. (1989) 'The public interest criterion in the decision to prosecute', *Journal of Criminal Law*, 53(4), pp. 485-502.

Denscombe, M. (2017) *Good Research Guide: For Small-Scale Social Research Projects*. 6th ed. London: Open University Press.

Denzin, N. K. and Lincoln, Y. S. (2003) 'Introduction: The Discipline and Practice of Qualitative Research'. In: N. K. Denzin and Y. S. Lincoln, eds. *Strategies of Qualitative Inquiry*. London: SAGE Publications, pp. 1-45.

Dobson, A. (2014) *Law academic provides expert comment on Gleision Mining case*. Available at: https://www.southwales.ac.uk/news/2014/law-academic-provides-expert-comment-gleision-min/ (Accessed: 15 November 2020).

Dodge, M., Bosick, S. and Antwerp, V. (2013) 'Do Men and Women Perceive White-Collar and Street Crime Differently? Exploring Gender Differences in the Perception of Seriousness, Motives, and Punishment', *Journal of Contemporary Criminal Justice*, 29(3), pp.399-415.

Doyle, D. M. and Scott, S. (2016) 'Criminal Liability for Deaths in Prison Custody: The Corporate Manslaughter and Corporate Homicide Act 2007', *The Howard Journal of Crime and Justice*, 55(3), pp. 295-311.

EU Skills. (2014) *Surrey Coroner's Court Matter of Shaun MASLIN (Deceased) Regulation 28 Report – Action to Prevent Future Deaths Energy &Utility Skills Response, Surrey Court*. Available at: https://www.judiciary.uk/wp-content/uploads/2014/06/2014-0277-Response.pdf (Accessed: 3 April 2022).

Exeter and Greater Devon Coroner Court. (2017) *Devon Feed Mills Survey of Delivery Arrangements-2017*. Judiciary. Available at: https://www.judiciary.uk/prevention-of-future-death-reports/david-alexander/ (Accessed: 3 March 2022).

Express and Star. (2009) 'Officer died after injury working at Stafford Prison', *Express & Star (Staffordshire News),* 10 September. Available at: https://www.expressandstar.com/news/2013/09/10/officer-died-after-injury-working-at-stafford-prison/ (Accessed:10 December 2022).

Express and Star. (2009) 'Family's tribute to bus driver', *Express & Star (Wolverhampton News)*, 23 May. Available at: https://www.expressandstar.com/news/2009/05/23/familys-tribute-to-bus-driver/ (Accessed:15 December 2020).

Fairclough, N. (2003) *Textual analysis for social research*. London: Routledge.

Farmers Weekly. (2019) 'Farm manager and company cleared of tractor death manslaughter', *Farmers Weekly*, 12 February. Available at: https://www.fwi.co.uk/news/farm-manager-and-company-cleared-of-tractor-death-manslaughter (Accessed: 10 July 2020).

Forti, G. and Visconti, A. (2020) 'From Economic Crime to Corporate Violence: The Multifaceted Harms of Corporate Crime'. In: M. L. Rorie, ed. *The Handbook of White-Collar Crime*. Hoboken: John Wiley and Sons, pp. 64-80.

Frauley, J. (2018) 'Conceptualization, theoretical practice and Crimes of the Powerful'. In: S. Bittle, L. Sinder, S. Tombs and D. Whyte, eds. *Revisiting Crimes of the Powerful, Marxism, Crime and Deviance*. Abingdon, Oxon: Routledge, pp. 2-20.

Frazer, S. R. (2021) *Determination by Sheriff Robert Frazer Under the Inquiries Into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016*. (BAN-B37-20). Available at: https://www.scotcourts.gov.uk/docs/default-source/cos-general-docs/pdf-docs-for-opinions/2021fai054.pdf?sfvrsn=4dd1b968_1 (Accesed:13 May 2021).

Friedrichs, D. (2015) 'Crimes of the Powerful and Definition of Crime'. In: G. Barak, ed. *The Routledge International Handbook of Crimes of the Powerful*. New York: Routledge, pp. 38-50.

Galvin, M. A. (2020) 'Substance or Semantics? The Consequences of Definitional Ambiguity for White-collar Research'. *Journal of Research in Crime and Delinquency*, 57(3), pp. 369-399.

George, Martin. (2015) 'Farm company's health and safety system 'fell apart' in run-up to death of worker Peter Buckle', *Eastern Daily Press*, 30 October. Available at: https://www.edp24.co.uk/news/farm-company-s-health-and-safety-system-fell-apart-in-810276 (Accessed: 15 March 2021).

Gobert, J. (2008) 'The Corporate Manslaughter and Corporate Homicide Act 2007- Thirteen years in the making but was it worth the wait?'. *Modern Law Review*, 71(3), pp. 413-433.

Gobert, J., and Punch, M. (2007) 'Because They Can'. In H. N. Pontell, and G. Geis, *International Handbook of White-Collar and Corporate Crime*. New York: Springer, pp. 98-122.

Goggin, C and Best, Lisa A. (2013) 'The Use of Scientific Inscriptions in Criminology and Criminal Justice Journals: An Analysis of Publication Trends between 1985 and 2009', *Journal of Criminal Justice Education*, 24(4), pp.517-535, DOI: 10.1080/10511253.2013.841971.

Gordon, A. (2017). Construction boss is jailed for 14 months for 'shocking failures' that led to the deaths of two workmen who fell from a balcony while renovating a multimillion-pound

Knightsbridge flat', *Daily Mail*, 7 July. Available at: https://www.dailymail.co.uk/news/article-4675274/Construction-boss-jailed-deaths-two-workmen.html (Accessed: 05 June 2021).

Gorton, A. and Stevens, R. (2011) *World Socialist Web Site*. Available at: https://www.wsws.org/en/articles/2011/09/mine-s17.html?view=print (Accessed: 15 February 2020).

Gottschalk, P. (2018) *Whistleblowing White-Collar Fraud Signal Detection*. Newcastle: Cambridge Scholars Publishing.

Gottschalk, P. and Benson, M. L. (2020) 'The Evolution of Corporate Accounts of Scandals from Exposure to Investigation', *British Journal of Criminology*, 60(4), pp. 949-969.

Gray, G. C. (2006) 'The Regulation of Corporate Violations: Punishment, Compliance and the Blurring of Responsibility', *British Journal of Criminology*, 46(5), pp. 875-892.

Greaves, P. (2019) *Manslaughter jury to inspect trailer in tragic Devon farm death*. Available at: https://www.devonlive.com/news/manslaughter-jury-inspect-trailer-tragic-2453680 (Accessed: 17 May 2021).

Grimshaw, D. (2010) *Fatal accident at work as man killed in steel girder accident*. Available at: https://www.irwinmitchell.com/news-and-insights/newsandmedia/2010/may/man-killed-in-steel-girder-accident-jq-643515 (Accessed: 25 October 2020).

Guardian. (2015) 'Kayak firm fined £200,000 over death of employee in industrial oven', *The Guardian*, 25 March. Available at: https://www.theguardian.com/uk-news/2015/mar/25/kayak-firm-fined-200000-over-death-of-employee-in-industrial-oven (Accessed: 05 February 2020).

Hall, S. and Winlow, S. (2018) "Big trouble or little evils: The ideological struggle over the concept of harm," *Zemiology*, pp. 107–126. Available at: https://doi.org/10.1007/978-3-319-76312-5_6.

Hartley, Richard D. (2010) *Snapshots of research: readings in criminology and criminal justice*. Thousand Oaks: SAGE Publications, pp.374-408. Available at: https://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=996375 (Accessed: 7 December , 2021).

Hawkins, K. (1990) 'Compliance strategy, prosecution policy and Aunt Sally: A Comment on Pearce and Tombs', *British Journal of Criminology*, 30, pp.444–467.

Health and Safety at Work etc. Act 1974, c.37. Available at: https://www.legislation.gov.uk/ukpga/1974/37/section/37 (Accessed: 10 July 2023).

Health and Safety Executive. (1996) *HSE* Available at: https://www.hse.gov.uk/pUbns/indg69.pdf (Accessed: 3 September 2020).

Health and Safety Executive. (2014). *Breach details - Case No. 4440527 Details for breach 02 - Thorn Warehousing Limited*, Available at: https://resources.hse.gov.uk/convictions-history/breach/breach_details.asp?SF=BID&SV=4440527002 (Accessed: 8 March 2021).

Health and Safety Executive. (2015a) *Gleision Mine Incident 15 September 2011*, Health and Safety Executive. Available at: http://www.mineaccidents.com.au/uploads/gleison-colliery-inrush-report.pdf (Accessed: 3 March 2022).

Health and Safety Executive. (2015b) *Investigation Procedure*. Available at: https://www.hse.gov.uk/foi/internalops/og/ogprocedures/investigation/investigation-procedure.pdf (Accessed: 20 May 2022).

Health and Safety Executive. (2016a) *Defendant details - Lincoln Proteins Limited*. Available at: https://resources.hse.gov.uk/convictions-history/defendant/defendant_details.asp?SF=DID&SV=1223505 (Accessed: 5 April 2022).

Health and Safety Executive. (2016b) *The inquest touching the death of Ben Collins- action to prevent future deaths*, Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2016/08/2016-0282-Response-by-HSE.pdf Accessed: 15 March 2021).

Health and Safety Executive. (2017a) *2015-16 names and details of fatalities*. HSE. Available at: https://www.hse.gov.uk/foi/fatalities/2015-16.htm (Accessed: 25 May 2020).

Health and Safety Executive. (2017b) *Details for Case No. 4476544 (Porvi Construcciones y Contratas S.L.)*. Available at: https://resources.hse.gov.uk/convictions-history/case/case_details.asp?SF=CN&SV=4476544 (Accessed: 25 May 2022).

Health and Safety Executive. (2018*) Breach details - Case No. 4421231 Details for breach 01- SPR Trailer Services Limited*. Available at: https://resources.hse.gov.uk/convictions-history/breach/breach_details.asp?SF=BID&SV=4421231001 (Accessed: 21 March 2022).

Health and Safety Executive. (2019) *Workplace fatal injuries in Great Britain 2018*. Available at: http://www.hse.gov.uk/statistics/pdf/fatalinjuries.pdf (Accessed: 07 August 2019).

Health and Safety Executive. (2020a) *In-year workplace deaths where HSE is the relevant enforcing authority*. Available at: https://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/investigation.htm (Accessed: 07 August 2020).

Health and Safety Executive. (2020b) 'Investigation'. Available at: https://www.hse.gov.uk/foi/fatalities/in-year-names.htm (Accessed: 7 August 2020).

Health and Safety Executive. (2020c) *Investigation - Stage 2: Decide whether to investigate - Additional guidance*. Available at: https://www.hse.gov.uk/foi/internalops/og/ogprocedures/investigation/decnrecordform.htm (Accessed: 3 April 2022).

Health and Safety Executive. (2021a). *Breach details - Case No. 4480968 Details for breach 01*. Available at: https://resources.hse.gov.uk/convictions-history/breach/breach_details.asp?SF=BID&SV=4480968001 (Accessed: 11 June 2021).

Health and Safety Executive. (2021b) Breach list Wood Treatment Limited. Available at: https://resources.hse.gov.uk/convictions-history/breach/breach_list.asp?ST=B&SN=F&EO=%3D&SF=CN&SV=4672629 (Accessed: 7 March 2022).

Health and Safety Executive. (2021c) *Breach List-Stonegrave Aggregates Limited*. Available at: https://resources.hse.gov.uk/convictions-history/breach/breach_list.asp?ST=B&SN=F&EO=%3D&SF=CN&SV=4605296 (Accessed: 3 May 2022).

Health and Safety Executive. (2022) *Crown censures taken by HSE since 1 April 1999*. Available at: https://resources.hse.gov.uk/convictions/documents/Crowncensures.htm (Accessed: 2 February 2022).

Health and Safety Executive. Freedom of Information Request, Reference No: 202208036, Ozdemir, 22 August 2022.

Health and Safety Executive. (no date) Case list. Available at: https://resources.hse.gov.uk/convictions-history/case/case_list.asp?PN=33&ST=C&EO=%3D&SN=F&SF=FAT&SV=Yes&SO=AODS# (Accessed: 3 April 2022).

Heap, V. and Waters, J. (2019) *Mixed Methods in Criminology*. London: Routledge.

Hébert, J., Bittle, S. and Tombs, S. (2019) 'Obscuring Corporate Violence: Corporate Manslaughter in Action'. *The Howard Journal of Crime and Justice*, pp. 1-26.

Hills, S. (1987) 'Preface', in S. Hills (ed.), *Corporate Violence. Injury and Death for Profit*, Totowa, NJ: Rowman and Littlefield, pp. vii–viii.

Hill, R. and Robertson, R. (2003) 'What sort of future for critical Criminology?', *Crime, Law and Social Change*, 39 (11), pp.91-115.

Hillyard, P. and Tombs, S. (2007) 'From 'crime' to social harm?'. *Crime Law Soc Change*, 48, pp. 9-25.

Howarth, D. (2000) *Discourse. Concepts in the Social Sciences*. Buckingham: Open University Press.

HSB, (2017) *Four men died during work for which the HSE says firms were "not capable or competent*. Issue 461, HSB, 1 September 2017. https://www-lexisnexis-com.soton.idm.oclc.org/uk/legal/results/enhdocview.do?docLinkInd=true&ersKey=23_T583931769&format=GNBFULL&startDocNo=0&resultsUrlKey=0_T583931771&backKey=20_T583931772&csi=355255&docNo=1 (21 August 2022).

Huisman, W. and Erp, J. V. (2013) 'Opportunities For Environmental Crime A Test of Situational Crime Prevention Theory'. *British Journal of Criminology*, (53), pp. 1178-1200.

ITV. (2021) *Bosley wood mill managers cleared of health and safety charges after fatal blast*. Available at: https://www.itv.com/news/granada/2021-04-30/bosley-wood-mill-managers-cleared-of-health-and-safety-charges-after-fatal-blast (Accessed: 3 June 2021).

ITV. (2016) *Employer jailed for killing teen who fell from ladder*. Available at: https://www.itv.com/news/westcountry/2016-10-15/employer-jailed-for-killing-teen-who-fell-from-ladder (Accessed: 6 June 2021).

Johnstone, P. (2015) *Man killed by overturned tractor in Camborne identified*. Available at: https://www.falmouthpacket.co.uk/news/13418132.man-killed-by-overturned-tractor-in-camborne-identified/ (Accessed: 3 January 2022).

Jones, S. (2011) 'Gleision mine manager arrested', *The Guardian*, 18 October. Available at: https://www.theguardian.com/uk/2011/oct/18/police-arrest-man-wales-mine-deaths (Accessed: 21 November 2020).

Kesselring, R. (2020), 'Introduction: Vignettes, Social Change and Solwezi Town' in f Rita Kesselring (Ed.) *Ethnographic Vignettes Social Change and Social Encounters in Solwezi,*

*Northwestern Zambia*. Basel: Institute of Social Anthropology, Basel Papers on Political Transformations, No. 20/21.

King, C. and Lord, N. (2018) *Negotiated Justice and Corporate Crime*. Palgrave Pivot. Available at: https://www.palgrave.com/gp/book/9783319785615. (Accessed: 10 August 2020).

Kramer, R. C., Michalowski, R. J. and Kauzlarich, D. (2002) 'The Origins and Development of the Concept and Theory of State-Corporate Crime'. *Crime and Delinquency*, 48 (2), pp. 263-282.

Latour, B. (1990) 'Drawing things together', in M. Lynch, and S. Woolgar (eds) *Representation in scientific practise*. Cambridge, MA: MIT Press, pp. 19–68.

Leary, A. et al. (2021) 'A thematic analysis of the prevention of future deaths reports in healthcare from HM Coroners in England and Wales 2016–2019', *Journal of Patient Safety and Risk Management*, 26(1), pp. 14–21. Available at: https://doi.org/10.1177/2516043521992651.

Levi, M. (1987) *Regulating Fraud*, London: Tavistock Publications Ltd.

Levi, M. and Lord, N. (2017) 'White-Collar and Corporate Crime', in Liebling, A., Maruna, S. and McAra, L. (eds) *The Oxford Handbook of Criminology*, Oxford, Oxford University Press, pp. 722–744.

Machin, D. and Mayr, A. (2012) 'Corporate crime and the discursive deletion of responsibility: A case study of the Paddington rail crash', *Crime Media Culture*, 9 (1) pp.63-82.

Manchester Evening News. (2013) *Manager fined after care home fire death*. Available at: https://www.manchestereveningnews.co.uk/news/local-news/manager-fined-after-care-home-857938 (Accessed: 10 February 2020).

Mascini, P. (2016) 'Comparing Assumptions Underlying Regulatory Inspection Strategies'. In: S. R. Van Slyke, M. L. Benson and F. T. Cullen, eds. *The Oxford Handbook of White Collar Crime*. New York: Oxford University Press, pp. 521-540.

Mason, J. (2002) *Qualitative Researching*. 2nd ed. London: SAGE.

Matthews, Lynda R., Fitzpatrick Scott J., and Bohle, Philip. (2014) 'Investigation and prosecution following workplace fatalities: Responding to the needs of families', *The Economic and Labour Relations Review*, 25(2), pp. 253-270. DOI: 10.1177/1035304614534350.

Matthews, R. A. and Kauzlarich, D. (2000) 'The Crash of Valujet Flight 592: A Case Study In State-Corporate Crime', *Sociological Focus*, 33(3), pp. 281-298.

McKenna, C. and Olswang, N. (2014) *Corporate manslaughter update: MNS Mining Limited*. Available at: https://www.lexology.com/library/detail.aspx?g=d1941ae7-7719-445c-8e73-055aaa486383 (Accessed: 20 September 2020).

McKewn, R. (2014) 'Jail for company director Paul O'Boyle after worker Ian Middlemiss is crushed to death by two-tonne sandbox'. *Daily Echo*, 29 August. Available at: https://www.dailyecho.co.uk/news/11441592.jail-for-company-director-paul-oboyle-after-worker-ian-middlemiss-is-crushed-to-death-by-two-tonne-sandbox/ (Accessed: 3 March 2022).

Menis, S. (2017) 'The Fiction of the Criminalisation of Corporate Killing', *The Journal of Criminal Law*, 81(6), pp. 467-477.

Michalowski, Raymond J. A. (2015) 'What is Crime?', *Critical Criminology*, 24, pp. 181-199.

Morris, S. (2013) 'Mine boss and company to face trial over flooding deaths', *The Guardian*, 18 September. Available at: https://www.theguardian.com/uk-news/2013/sep/18/mine-boss-company-face-trial (Accessed 2 December 2019).

Morris, S. (2014) 'Gleision colliery: the pit disaster that devastated a Welsh mining community', *The Guardian*, 19 June. Available at: https://www.theguardian.com/uk-news/2014/jun/19/gleision-colliery-tragic-pit-disaster-welsh-mining-community (Accessed 3 January 2020).

Morris, S. (2021) 'Families and survivors still seek answers to Gleision mine disaster', *The Guardian*, 15 September. Available at: https://www.theguardian.com/uk-news/2021/sep/15/families-survivors-still-seek-answers-gleision-mine-disaster (Accessed: 2 January 2022).

Murray, D. (2016) *Inquiry Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Into the Death of Ian John Leitch Black*. (B88/16). Available at: https://www.scotcourts.gov.uk/search-judgments/judgment?id=2bcb27a7-8980-69d2-b500-ff0000d74aa7 (Accessed: 7 January 2021).

Nellaney, D. (2015) 'Widow awarded record damages in fatal accident case', *Scottish Legal News*. 26 June. Available at: https://www.scottishlegal.com/article/widow-awarded-record-damages-in-fatal-accident-case (Accessed:3 January 2021).

Noble, J. (2017) Inquest jury records conclusion of accidental death for grandfather tipped from cherry picker in Felixstowe. *Ipswich Star*: https://www.ipswichstar.co.uk/news/inquest-jury-records-conclusion-of-accidental-death-for-grandfather-tipped-2775208 (Accessed: 20 May 2021).

Norfolk Coroner Court. (2015) *Regulation 28: Report to Prevent Future Deaths*, Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2016/01/Buckle-2015-0425.pdf (Accessed: 15 March 2021).

North Wales Live. (2014) 'Deeside: Man died after falling 40ft off ladder', *North Wales Live*, 24 June. Available at: https://www.dailypost.co.uk/news/north-wales-news/deeside-man-died-after-falling-7320164 (Accessed: 20 June 2021).

O'Leary, M., and Elmes, S. (2018) *MoD condemned over tragic death of Plymouth Royal Navy engineer*. Available at: https://www.plymouthherald.co.uk/news/plymouth-news/mod-condemned-over-tragic-death-1192298 (Accessed: 10 June 2021).

O'Mahoney, Daniel. (2017) *Building firm told to pay £200k over concrete block death at the Crick*. Available at: https://www.standard.co.uk/news/london/building-firm-told-to-pay-ps200k-over-concrete-block-death-at-the-crick-a3525116.html (Accessed: 20 February 2020).

Parry, H. (2015) 'Construction boss is fined £75,000 after a worker was buried alive and suffocated to death when the trench he was digging collapsed on him', *Daily Mail*, 22 July. Available at: https://www.dailymail.co.uk/news/article-3170466/Construction-boss-fined-75-000-worker-buried-alive-suffocated-death-trench-digging-collapsed-him.html (Accessed: 23 May 2020).

Parsons, S. (2018) 'The Corporate Manslaughter and Corporate Homicide Act 2007 Ten Years On: Fit for Purpose', *The Journal of Criminal Law*, 82(4), pp. 305-310.

Parton, David A., Hansel, M., and Stratton, John R. (1991) 'MEASURING CRIME SERIOUSNESS Lessons from the National Survey of Crime Severity'. *British Journal of Criminology*, 31(1), pp. 72-85.

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods*. 3rd ed. London: SAGE.

Pearce, F. (1976) *Crimes of The Powerful: Marxism, Crime and Deviance*. London, Pluto Press Limited.

Pearce, F. and Tombs, S. (1998) *Toxic Capitalism: Corporate Crime and Chemical Industry*. Aldershot: Dartmouth Publishing Company Limited.

Pemberton, S. (2007) 'Social harm future(s): exploring the potential of the social harm approach'. *Crime Law Soc Change*, 48, p. 27–41.

Pennink, E. (2017) 'Construction boss jailed after 'shocking safety failure' saw workmen fall to their deaths hauling sofa up balcony', *Mirror*, 7 July. Available at: https://www.mirror.co.uk/news/uk-news/construction-boss-jailed-after-shocking-10755697 (Accessed: 9 June 2021).

Pinsent Masons. (2017) Corporate manslaughter and corporate homicide ongoing prosecutions and verdicts. Available at: https://exclusive.iosh.com/media/3259/corporate-manslaughter-and-homicide-may-2017.pdf (Accessed: 4 February 2020).

Pontell, H. N., Calavita, K. and Tillman, R. (1984) 'Corporate Crime and Criminal Justice System Capacity: Government Response to Financial Institution Fraud', *Justice Quarterly*, 11(3), pp. 383-410.

Prior, G. (2013) *Highways worker killed in collision with car*. Available at: https://www.constructionenquirer.com/2013/08/15/highways-worker-killed-in-car-collision/ (Accessed: 6 March 2021).

Prior, G. (2017) *Firms sentenced after four killed in site excavation tragedy*. Available at: https://www.constructionenquirer.com/2017/05/25/four-killed-in-site-excavation-tragedy/ (Accessed: 5 February 2020).

Prior, G. (2021) *Worker killed in 14 metre fall through temporary platform*. Available at: https://www.constructionenquirer.com/2019/02/18/worker-killed-in-14-metre-fall-through-temporary-platform/ (Accessed: 5 February 2021).

Punch, M. (1996) *Dirty Business*. London: Sage Publications.

Punch, M. (2000) 'Suite violence: Why managers murder and corporations kill', *Crime, Law and Social Change*, 33, pp.243-280.

Quinney, Earl R. (1964) 'The Study of White-Collar Crime: Toward A Reorientation in Theory and Research', *Journal of Criminal Law and Criminology*, 55 (2), pp. 208-214.

R v Wood Treatment Limited and George Boden. (2021) *Chester Crown Court, Case No: T20197350*. Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2021/07/R-v-WTL-and-Boden-sentencing-remarks.pdf (Accessed: 24 March 2022).

Rannard, S. (2017) *Liquidated Recycler Fined £1 For Worker's Death*. Available at: https://www.insidermedia.com/news/midlands/liquidated-recycler-fined-1-for-workers-death (Accessed: 20 September 2020).

Regina v MNS Mining LTD and Malcolm Fyfield (2014). Swansea Crown Court, Case No: T20137046, *Swansea Crown Court*.

Regina v Ozdil Investments Ltd. and Koseoglu Metal Works Ltd. (2017). Chelmsford Crown Court, Case No: T20167062; T20167063, *Chelmsford Crown Court*.

Reiman, J. (2007) *The Rich Get Richer and The Poor Get Prison: Ideology, Class and Criminal Justice*. Boston: Pearson/Allyn and Bacon.

Ridler, Faith. (2021) 'Owner of wood mill is cleared of gross negligence manslaughter after explosion killed four workers as he admits health and safety offence', *Daily Mail*, 29 April. Available at: https://www.dailymail.co.uk/news/article-9526141/Owner-wood-cleared-gross-negligence-manslaughter.html (Accessed: 12 December 2021).

Riley, J. (2014). 'Farmworker crushed after failing to apply handbrake'. *Farmers Weekly*, 30 October. Available at: https://www.fwi.co.uk/news/farmworker-crushed-after-failing-to-apply-handbrake (Accessed: 27 March 2021).

Roper, V. (2018) 'The Corporate Manslaughter and Corporate Homicide Act 2007-A 10 Year Review'. *The Journal of Criminal Law*, 82(1), pp. 48-75.

Rose, D. (2014) 'I Need Reassurance That Shaun's Death Was Not In Vain,' Says Partner Following Inquest. Available at: https://www.irwinmitchell.com/news-and-insights/newsandmedia/2014/june/gas-worker-killed-by-100kg-steel-cap-which-blew-off-pipe (Accessed: 20 October 2020).

Rothe, D. and Kauzlarich, D. (2016) *Crimes of the Powerful*. London: Routledge.

Ruggiero, V. (2015) *Power and Crime*. Abingdon, Oxon: Routledge.

Russell, S. (2014) 'Hopton man killed by falling crane part at Shipdham site died in tragic accident, jury concludes', *Eastern Daily Press*,10 October. Available at: https://www.edp24.co.uk/news/hopton-man-killed-by-falling-crane-part-at-shipdham-site-715276 (Accessed: 5 January 2021).

Safety and Health Practitioner. (2011) *Untrained worker killed in gas explosion*. Available at: https://www.shponline.co.uk/emergency-procedures/untrained-worker-killed-in-gas-explosion/ (Accessed: 12 November 2021).

Safety and Health Practitioner. (2014) Corporate manslaughter "ruled out" following four deaths, *SHP*. Available at: https://www.shponline.co.uk/legislation-and-guidance/corporate-manslaughter-ruled-out-following-four-deaths/ (Accessed: 12 December 2020).

Sentencing Council, (2016) *Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences Definitive Guideline*, Available at https://www.sentencingcouncil.org.uk/publications/item/health-and-safety-offences-corporate-manslaughter-and-food-safety-and-hygiene-offences-definitive-guideline/ (Accessed: 29 January 2022).

Services, A. (2013) *Company fined after death revealed gaps in MEWP emergency training*. Available at: https://www.arcoservices.co.uk/News/blog-article/company-fined-after-death-revealed-gaps-in-mewp-emergency-training#:~:text=Firesafe%20Installations%20Limited%20has%20been,to%20access%20high%20work%20areas (Accessed: 13 March 2022).

Shropshire Star. (2015) *Inquest told of frantic battle to free tragic Argos lorry driver in Oswestry*. Available at: https://www.shropshirestar.com/news/2015/04/16/inquest-told-of-frantic-battle-to-free-tragic-argos-lorry-driver-in-oswestry/ (Accessed: 14 May 2021).

Simpson, S. S. (2013) ' White-Collar Crime: A Review of Recent Developments and Promising Directions for Future Research', *Annual Review of Sociology*, Volume 39, pp. 309-331.

Simpson, S. S. (2019) 'Reimagining Sutherland 80 years after white collar crime', *Criminology*, 57(2), pp. 189-207.

Simpson, S. S. and Weisburd, D. (2009) 'Introduction'. In: S. S. Simpson and D. Weisburd, eds. *The Criminology of White-Collar Crime*. New York: Springer, pp. 63-79

Skidmore, Z. (2021) 'Call for inquest into Gleision Colliery mining disaster'. Available at: https://www.mining-technology.com/mines-projects/gleision-colliery-disaster/ (Accessed: 21 March 2022).

Slapper, G. (1993) 'Corporate manslaughter: An examination of the determinants of prosecutorial policy, *Social and Legal Studies*, 2(4), pp.423-443.

Slapper, G. (2010) 'Corporate Punishment', *Journal of Criminal Law*, 74(3), pp. 181-184.

Slapper, G. and Tombs, S. (1999) *Corporate Crime*. Harlow: Longman.

Slyke, S. and Bales, W. (2012) 'A contemporary study of the decision to incarcerate white-collar and street property offenders', *Punishment and Society*, 14(2), pp. 217-246.

Stake, R. E. (2003) 'Case Studies'. In: N. K. Denzin and Y. S. Lincoln, eds. *Strategies of Qualitative Inquiry*. London: SAGE Publications, pp. 134-164.

Stake, R. E. (2009) 'The Case Study Method in Social Inquiry'. In: R. Gomm, M. Hammersley and P. Foster, eds. *Case Study Method*. 7th ed. London: SAGE, pp. 18-30.

Stone, N. (2014) *Four lives, three years and no end to the upset and anger*. Available at: https://app.croneri.co.uk/feature-articles/four-lives-three-years-and-no-end-upset-and-anger (Accessed: 6 March 2020).

Strudwick, Matt. (2016) *M3 worker death inquest: Workmen hand dug in desperate attempt to free crushed colleague*. Available at: https://www.getsurrey.co.uk/news/surrey-news/m3-worker-death-inquest-workmen-11669468 (Accessed: 20 February 2021).

Surmiak, A. (2018) 'Confidentiality in qualitative research involving vulnerable participants: researchers' perspectives'. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 19(3). https://doi.org/10.17169/fqs-19.3.3099.

Surmiak, A. (2020) 'Should we Maintain or Break confidentiality? The Choices Made by Social Researchers in the Context of Law Violation and Harm'. *J Academic Ethics*, (18), 229–247. https://doi.org/10.1007/s10805-019-09336-2.

Surrey Coroner's Court. (2014) *The Inquests Touching the Death of Shaun MASLIN A Regulation 28 Report – Action to Prevent Future Deaths*, Report No:RT4079, Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2015/01/Maslin-2014-0277.pdf (Accessed: 3 April 2022).

Surrey Coroner's Court. (2016) *The Inquests Touching the Death of Ben Andrew Collins A Regulation 28 Report-Action to Prevent Future Deaths*, Report No: RT4563, Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2016/11/Collins-2016-0282.pdf (Accessed: 15 March 2021).

Sutherland, Edwin. H. (1949) *White-Collar Crime*. New York: Dryden.

Sutherland, Edwin. H. (1983) *White-Collar Crime: The Uncut Version*. New Haven: CT: Yale University.

Tappan, Paul W. (1946) 'Who Is the Criminal?', *American Sociological Review*, 12(1), pp. 96-102. Available at: http://www.jstor.org/stable/2086496.

Tevlin, T. (2017) *British Safety Council*. Available at https://www.britsafe.org/publications/safety-management-magazine/safety-management-magazine/2017/three-directors-jailed-over-workers-roof-fall-death/ (Accessed: 20 July 2020).

The National Archives, (2020) *2008-09 names and details of fatalities*, Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20201209151704/https://www.hse.gov.uk/foi/fatalities/2008-9.htm (Accessed: 10 December 2020).

The Newsroom. (2010) 'Soldier dies in quarry fall', *The Scotsman*. Available at: https://www.scotsman.com/news/soldier-dies-quarry-fall-1718148 (Accessed 9 May 2020).

Thompson, S. (2015) 'Baldwins Crane Hire ordered to pay nearly £1 million after death of Lindsay Easton at Scout Moor quarry in Edenfield', *Bury Times*, 22 December. Available at: https://www.burytimes.co.uk/news/14161406.baldwins-crane-hire-ordered-to-pay-nearly-1-million-after-death-of-lindsay-easton-at-scout-moor-quarry-in-edenfield/#:~:text=Lindsay%20Easton%20was%20killed%20while,Easton%20on%20August%2015%2C%202011 (Accessed: 9 August 2020).

Tilley, C. (2012) 'Colchester dad died after a ton of metal fell on him'. *Gazette Standard*, 25 June. Available at: https://www.gazette-news.co.uk/news/9780499.colchester-dad-died-after-a-ton-of-metal-fell-on-him/ (Accessed: 13 July 2020).

Tombs, S. (2007) 'Violence', Safety crimes and Criminology', *British Journal of Criminology*, 47, pp. 531-550.

Tombs, S. (2018) 'The UK's corporate killing law: UN/fit for purpose?' *Criminology and Criminal Justice*, 18(4), pp. 488-507.

Tombs, S. and Whyte, D. (2007) *Safety crimes*. London; Willian Publishing.

Tombs, S. and Whyte, D. (2013) 'The Myths and Realities of Deterrence in Workplace Safety Regulation', *British Journal of Criminology*, (53), pp. 746-763.

Tombs, S. and Whyte, D. (2015) *The Corporate Criminal: Why Corporations Must be Abolished*. Abingdon, Oxon; New York: Routledge.

Trahan, A. and Stewart, D. M. (2013) 'Toward a Pragmatic Framework For Mixed-Methods Research in Criminal Justice and Criminology', *Applied Psychology in Criminal Justice*, 9(1), pp.59-74.

Trevino, A. J. (2019) *Clinard and Quinney's Criminal Behaviour Systems*. 4th ed. New York: Routledge.

Vennesson, P. (2008) 'Case studies and process tracing: theories and practices.' In: D. Della Porta and M. Keating, eds. *Approaches and Methodologies in the Social Sciences A Pluralist Perspective*. Cambridge: Cambridge University Press, pp. 223-240.

Waddington, P., Badger, D. and Bull, R. (2005) 'Appraising the Inclusive Definition of workplace 'Violence', *British Journal of Criminology*, 45(2), pp. 141-164.

Wadham, C. (2021) *Rydon fined £500k after worker falls to his death. Construction News*, 18 February. Available at: https://www.constructionnews.co.uk/health-and-safety/rydon-fined-500k-after-worker-falls-to-his-death-18-02-2019/#:~:text=On%2024th%20July%202015%2C%20Vasile,and%20died%20from%20his%20injuries (Accessed: 13 May 2020).

Wayland Farms Ltd. (2015) *Wayland Farms Ltd Response*, Judiciary. Available at: https://www.judiciary.uk/wp-content/uploads/2015/11/2015-0425-Response.pdf (Accessed: 15 March 2021).

Wells, C. (1991) 'Inquests, inquiries and indictments: The official reception of death by disaster', *Legal Studies*, 11(1), pp. 71-84. doi:10.1111/j.1748-121X.1991.tb00623.x.

Weisburd, D. and Britt, C. (2014) *Statistics in Criminal Justice*. New York: Springer Science Business Media.

Weisburd, D. and Waring, E. (2001) *White-Collar Crime and Criminal Careers*. Cambridge, UK: Cambridge University Press.

Wheeler, Andrew P. (2016) 'Tables and graphs for monitoring temporal crime trends: Translating theory into practical crime analysis advice', *International Journal of Police Science and Management*, 18(3), pp.159-172.

Whyte, D. (2018) 'The Autonomous Corporation: The Acceptable Mask of Capitalism'. *King's Law Journal*, 29(1), pp. 88-110.

Whyte, D. (2020) *Ecocide Kill the corporation before it kills us*. Manchester: Manchester University Press.

Wilkinson, D. (2015) 'Rochdale lorry driver William Barker's death was 'accidental' when he was crushed by car park barrier', *Manchester Evening News*, 19 April. Available at: https://www.manchestereveningnews.co.uk/news/greater-manchester-news/rochdale-lorry-driver-william-barkers-9071698 (Accessed:13th of July 2020).

Wood, L. (2014) *Inquiry Under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 Into The Death of Stephen Thomson*. *Scottish Courts and Tribunals*. Available at: https://www.scotcourts.gov.uk/search-judgments/judgment?id=a8808ca6-8980-69d2-b500-ff0000d74aa7#:~:text= (Accessed: 7 July 2021).

World Health Organisation. (2014) *Injuries and violence: the facts 2014*. Available at: https://www.who.int/violence_injury_prevention/media/news/2015/Injury_violence_facts_2014/en/ (Accessed: 15 October 2020).

Yin, R. (2014) *Case Study Research Design and Methods.* 5th ed. London: Sage Publications.