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Review Article

Corporate Manslaughter in the UK: Lessons for Australia

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ABSTRACT

Prior to, and since the passage of the Corporate Manslaughter and Corporate Homicide Act 2008 (CMCHA) in the United Kingdom (UK), prosecutions for serious workplace health and safety offences have been mostly underwhelming. Australia has now followed the UK in legislating for industrial manslaughter within the various workplace health and safety laws across many of its states and territories. The aim of this paper is to explore the industrial manslaughter legislation across Australia and discusses the lessons which may be learned from the UK. An analysis of the CMCHA was undertaken to determine whether it has lived up to expectations and if there may be lessons to be learned for Australia as it embarks on its post-harmonization journey. A review of publications found that the CMCHA had fallen short of expectations within its first decade of existence in the UK in both the number of successful prosecutions and in the severity of the punishments handed down. The purported deficiencies in the prosecutorial success of the United Kingdom's CMCHA provides an opportunity for Australia to heed and avoid these deficiencies.

1. Introduction

In most legislative jurisdictions across Australia, the concept of industrial manslaughter has been enacted. While Australia takes its first tentative steps in prosecuting companies under these provisions, there are lessons to be learned from other countries, particularly the United Kingdom (UK) from where Australia has a long history of adopting and adapting health and safety-related legislation. Prior to Federation, the colonies adopted a number of UK health and safety laws to improve the working lives of its citizens, including the various versions of the Factories Acts and mining legislation. The conclusion of the nineteenth century and the dawn of the twentieth witnessed a cluster of parliamentary action which bore the emergence of health and safety legislation across Australia.

Major reforms were initiated in Australia in the 1970's, which were based on the legislative changes occurring in the United Kingdom following the Robens Report (Bluff et al., 2004). The modernizations proposed by the Robens Committee involved consolidating a number of disparate statutes into one overarching legislative framework with a principal Act and subordinate Regulations which were to be supported by various non-statutory Codes of Practice, moving the UK away from a prescriptive to a performance standard of legislation (Bluff et al., 2004). The reforms placed broader general duties of care on parties who had a significant influence on health and safety, including employers, designers, manufacturers, and suppliers (MacDonald et al., 2012).

Given that the Federal Constitution of Australia does not empower the Commonwealth to make and pass laws with regards to matters of workplace health and safety (Johnstone, 2023; Windholz, 2013a), the individual state and territory governments (and the Commonwealth for those under its jurisdiction) have "primary responsibility for occupational health and safety legislation, regulation, enforcement and more general guidance" (MacDonald et al., 2012, p. 172). This disparity led to ultimately what has been described as regulatory fragmentation (Lo, 2012), with each state and territory tinkering with its own legislation without much forethought for workers in different jurisdictions who were exposed to similar risks but who were afforded different levels of legal protection, and for organizations of all sizes which operated across multiple state borders having to comply with each individual statute (Johnstone, 2008).

Since 2001, Australian governments have recognized the advantages of implementing a consistent approach to workplace health and safety legislation. In December 2007, the Council of Australian Governments (COAG) agreed to a new model of intergovernmental cooperation (Windholz, 2013a) and by July 2008 had formally committed to the harmonization of Australian work health and safety (WHS) legislation. This agreement committed the Commonwealth, state and territory governments to implement a uniform legislative framework (Glavan & Palaneeswaran, 2012) and led to the development of the Model Work

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Health and Safety Act 2010.

While these reforms were intended to be in place by January 1, 2012, only the Commonwealth, New South Wales, Queensland, Northern Territory, and the Australian Capital Territory were ready with the harmonized legislation (Windholz, 2013b). In two states, Western Australia (WA) and Victoria (Vic), the passage of the harmonized legislation was disrupted by changes of government from Labor to the more conservative Liberal, who were not willing to implement the Labor-leaning legislation. However, by 2021, both states had enacted workplace safety legislation which included the offence of industrial manslaughter (WA) or workplace manslaughter (Vic).

The success, and more importantly, the opportunities for improvement of the CMCHA should be closely monitored by Australian legislatures, particularly in the case of prosecutions, the outcomes of which in Australian courts have been described as inadequate (Johnstone, 2003) and inconsistent (Boland, 2018). The aim of this paper was to explore the industrial manslaughter legislation across Australia and discuss the lessons which may be learned from the UK.

This paper is organized as follows. First, a brief overview of the introduction of industrial manslaughter legislation in Australia is presented in section 2. Section 3 provides a summary of prosecutions to date in Australia under the various new legislations. The Corporate Manslaughter and Corporate Homicide Act and the reasons for its introduction in the UK are presented in section 4. The CMCHA is then analyzed in section 5 and this paper discusses whether it has adequately fulfilled its legislative and social function in reducing workplace fatalities and holding large corporations to account. In section 6, the key aspects of the two Acts is discussed, comparing and contrasting key elements. Finally, section 7 of this paper discusses whether prosecution, or the threat of prosecution, is enough of a deterrent to recalibrate the approach taken by organizations to implement robust and meaningful health and safety systems to provide a safe workplace. Conclusions and recommendations are formulated and discussed in the final section of the paper.

2. Industrial manslaughter in Australia

According to Clough (2005), the push for the introduction of a workplace manslaughter offence in Australia was driven by three factors. First, workplace deaths fall under the general provisions of workplace safety laws whereby organizations are held accountable for failing to maintain a safe workplace and thus do not reflect the seriousness of the breach for individuals. Secondly, large organizations tended to escape prosecution whereas prosecutions against smaller companies have been more frequent and more successful. Thirdly, penalties for a workplace fatality handed down by local magistrates were generally inadequate and did not reflect the gravity of the offence.

In November 2003, the Legislative Assembly of the Australian Capital Territory (ACT) passed the Crimes (Industrial Manslaughter) Amendment Act 2003, making it the first jurisdiction to introduce industrial manslaughter legislation in Australia (Richards & Sarre, 2005; Sarre, 2007). These provisions remained in place until June 2021 when industrial manslaughter offences under work health and safety legislation were enacted in the Work Health and Safety Act 2011 (ACT). To date, there has not been a prosecution for a workplace fatality under the industrial manslaughter provisions in this territory.

One month after the ACT legislation took effect in 2004, the Commonwealth government introduced the Occupational Health and Safety (Commonwealth Employment Employee Involvement and Compliance) Bill 2004 (Johnson, 2008; Vucetic et al., 2023). This bill was to exempt Commonwealth employees from the provisions of the ACT legislation (Sarre, 2010) and in effect created a situation whereby different employees within the same workplace were covered by separate health and safety legislation (Johnson, 2008).

Victoria passed the Occupational Health and Safety Act 2004 which included a duty not to 'recklessly endanger persons at the workplace'. New South Wales introduced the Occupational Health and Safety Amendment (Workplace Deaths) Bill 2005 to make it an offence for a person who owes a duty under the Act to engage in reckless conduct that causes death at a workplace (Johnson, 2008). Towards the end of 2004, a panel of experts prepared a report for the state's regulatory authority for workplace health and safety, recommending against specific legislation for industrial manslaughter, arguing instead for additional penalties in the existing Occupational Health and Safety Act 2000 (Foster, 2006).

In South Australia, a private member's bill was tabled in December 2004 proposing maximum penalties of 20 years' imprisonment for individuals and fines of $18 million for companies. The bill, modelled on the ACT provisions (Sarre, 2006), was defeated (Guthrie & Waldeck, 2008). By March 2022, however, a Labor government was elected which had promised during the election campaign to introduce industrial manslaughter legislation (Johnstone, 2023), becoming law in July 2024.

Prior to adopting its own rendering of the Model WHS Act, Western Australia's Occupational Safety and Health Act 1984 already included provisions for industrial manslaughter (Johnson, 2008). Under these provisions, an individual could be fined $550,000 and imprisoned for five years for a first offence or $680,000 and imprisonment for five years for a subsequent offence. For a body corporate, a first offence carried a fine of $2,700,000 or $3,500,000 for a subsequent offence. These penalties were significantly increased when the Work Health and Safety Act 2020 was enacted.

In April 2017, following two high profile incidents at Dreamworld and the Eagle Farm Racecourse which claimed six lives, the Queensland government ordered an independent best practice review of workplace health and safety (Rawling & Schofield-Georgeson, 2018). The review made 58 recommendations including creating the offence of industrial manslaughter. It also recommended the reinstatement of several arrangements which had been repealed by the national harmonization process that had been "broadly supported by stakeholders" (Lyons, 2017, p. 7). One such revocation was the reverse onus of proof provision, leaving the regulator to prove and demonstrate that the employer was at fault for a breach of the legislation, whereas previously the onus of proof was on the employer to prove no fault. In August 2017, the government introduced legislative changes to create the offence of industrial manslaughter in Queensland.

A review of the Model Work Health and Safety Act in 2018 recommended that it be amended to include a new offence of gross negligence industrial manslaughter (Boland, 2018; Johnstone, 2023). The states and territories that had previously adopted the Model Work Health and Safety Act commenced introducing provisions (refer Table 1). The Northern Territory added manslaughter provisions in 2019 to Part 2 of its Work Health and Safety (National Uniform Legislation) Act 2011, which took effect from February 1, 2020. The provisions were tested when charges were laid against a building company, Kalidonis NT and its director, following the death of a worker. The manslaughter charges were later dropped, though the company was found guilty in August 2024 of failing to comply with a health and safety duty.

New South Wales became the final mainland state to enact industrial manslaughter legislation in mid-2024. Only the state of Tasmania remains to implement industrial manslaughter provisions.

The penalties for industrial manslaughter in Australia are not consistent. Penalties for individuals for industrial manslaughter vary from 20 years' imprisonment in three Australian states and one territory, to life imprisonment in the Northern Territory. Western Australia is the only state in which, as well as facing imprisonment, an individual may also be fined up to $5 million. Body Corporate fines for industrial manslaughter vary from $10 million in Western Australia to $20 million in New South Wales.

3. Industrial manslaughter prosecutions in Australia

Since the implementation of the individual jurisdictional laws, there

Table 1
Current industrial manslaughter provisions in Australian jurisdictions.

Jurisdiction	Law in Force	Maximum Penalties
Commonwealth	Work Health and Safety Act 2011 Section 30A Commenced July 1, 2024	In the case of an offence committed by an individual, 25 years imprisonment. In the case of an offence committed by a body corporate, $18,000,000.
Queensland	Work Health and Safety Act 2011 Section 34C Commenced October 23, 2017	For an individual 20 years' imprisonment. For a body corporate 100,000 penalty units (currently $15,480,000).
Northern Territory	Work Health and Safety (National Uniform Legislation) Act 2011 Section 34B Commenced February 1, 2020	For an individual, imprisonment for life. For a body corporate, 65,000 penalty units (currently $11,440,000).
Victoria	Occupational Health and Safety Act 2004 Section 39G Commenced July 1, 2020	Imprisonment for 25 years for a natural person. 100,000 penalty units for a body corporate (currently $19,231,000).
Australian Capital Territory	Work Health and Safety Act 2011 Section 34A Commenced August 5, 2021	In the case of an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking, imprisonment for 20 years. In the case of an offence committed by a body corporate, $16,500,000.
Western Australia	Work Health and Safety Act 2020 Section 30A Commenced March 31, 2022	For an individual, imprisonment for 20 years and a fine of $5,000,000. For a body corporate, a fine of $10,000,000.
South Australia	Work Health and Safety Act 2012 Section 30A Commenced July 1, 2024	In the case of an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking: 20 years imprisonment. In the case of an offence committed by a body corporate: $18,000,000.
New South Wales	Work Health and Safety Amendment (Industrial Manslaughter) Act 2024 Section 34C Commenced July 1, 2024	For an individual, imprisonment for 25 years. For a body corporate, $20,000,000.
Tasmania	No current provision.	Not applicable.

have been five convictions under the various industrial manslaughter instruments. All prosecutions occurred with small organizations. What follows is a summary of the reported prosecutions to date.

Queensland was the first jurisdiction to record a conviction for company industrial manslaughter. In *R v Brisbane Auto Recycling Pty Ltd* [2020], two directors were convicted and handed a 10-month prison sentence, suspended for two years, and the company fined $3 million following the death of a worker who was struck by a reversing forklift (McMaster et al., 2021). The forklift, driven by an unlicensed operator, crushed the victim between the forklift and a tilt tray truck. The investigation found that the company had no safety systems in place (Office of the Work Health and Safety Prosecutor, 2020). The penalty imposed was more than the annual turnover of the company, which at the time was $2.5 million (*R v Brisbane Auto Recycling, 2020*).

In March 2022, Queensland also recorded the first industrial manslaughter conviction for an individual who was not a company officer. Jeffrey Owen was sentenced to 5 years' imprisonment for the death of his friend who was crushed by a falling generator being moved from the back of a truck. The defense lawyers had initially argued that a friend who was simply helping a friend could not be considered a worker under the WHS Act, but this was dismissed as the definition of worker includes volunteers with the same duties owed whether they are paid or not (Inglis & Keenan, 2022).

The third conviction for breaches of section 34C of the Act in Queensland occurred in June 2024 following the death of a worker in 2021. Narellan Pools Pty Ltd was fined $1.5 million after a worker inadvertently placed himself between a mobile crane and its load, a 650 kg fiberglass pool. Shortly afterwards, the victim was struck by the crane and knocked to the ground. The crane operator continued and drove over the top of the victim (Office of the Work Health and Safety Prosecutor, 2024).

The state of Victoria recorded a conviction in *R v LH Holding Management Pty Ltd & Hanna* [2024]. In October 2021, a 25-year-old subcontractor died after a forklift being operated by the sole director (Laith Hanna) with a raised load on a sloping driveway tipped over and landed on top of the victim. The company and the director entered guilty pleas. LH Holding was fined $1.3 million, and Hanna was convicted and placed on a two-year Community Correction Order, with additional conditions that he complete 200 hours of unpaid community work and complete a course in forklift operation. The company and Hanna were also ordered to pay $120,000 in compensation to the worker's family for pain and suffering (Morgan, 2024).

The only other state or territory to record a conviction under an industrial manslaughter statute is Western Australia. MT Sheds (WA) Pty Ltd, a small company that constructed sheds, was convicted under the industrial manslaughter provisions of the now repealed Occupational Safety and Health Act 1984. While installing roofing sheets on a large machinery shed at a height of 9 metres, and without fall protection or an appropriate high risk work license, two workers fell with one suffering fatal injuries and the other multiple fractures. The company's owner, Mark Thomas Withers was sentenced to two years and two months' imprisonment (for which he served eight months, with the remaining term suspended) and fined $2,250. MT Sheds was fined $550,000 and an additional $55,000 for various other breaches of the Act in relation to the incident. To pay this fine, the company MT Sheds (WA) Pty Ltd was liquidated and the workers all lost their employment (Australian Securities and Investments Commission, 2021). This industrial manslaughter charge caused hardship to more than just the company owner.

It is, perhaps, too early to determine whether the individual Australian industrial manslaughter legislations are achieving the aim of keeping workers safe and organizations of all sizes to account. Of the eight jurisdictions that have legislated for industrial manslaughter in line with the Model WHS Act, five have only enacted those laws in the past three years. The two states that have recorded prosecutions, Queensland and Victoria, have held legislation since 2017 and 2020 respectively. While to date there has not been a conviction against a large organization, thus far the courts have taken an unsympathetic position when sentencing the guilty. For the vigilant, the message of deterrence is clear. The first prosecution of a large organization will, and should, be closely monitored.

4. Corporate manslaughter: the United Kingdom's experience

The CMCHA promised so much, not least of which was to be able to hold large organizations – and individual senior employees – to account for avoidable workplace deaths. There was a general sense that the legal system was not preserving the public's confidence in the law's ability to satisfactorily hold corporations to account (Almond, 2007).

At the dawn of the new millennium, there was a political desire by the then Labour government for change, supported by bodies such as trade unions, victims' organizations, and public interest groups (Gobert, 2005). In May of 2000, the government published a consultation paper, followed by a draft Corporate Manslaughter Bill in March 2005. Some of

the provisions of the bill were so contentious (Barrett, 2008) that political will inevitably led to compromise as the government trod the precarious path of the public's demand for change while at the same time ensuring the interests of the economy (Almond & Colover, 2012). It took another two years of negotiation from the draft bill until the CMCHA was enacted.

The Act came into force in April 2008. It is so called owing to the equivalent offence of manslaughter in Scotland being that of culpable homicide (Johnson, 2008). While the Act is designed to keep corporations in check, there have been some contentions that the title is misleading, given that bodies such as government agencies and trade unions, for example, are also captured within its remit (Johnson, 2008).

Prior to the CMCHA, the barrier to successful corporate prosecution in the United Kingdom was often due to the identification doctrine, under which, a 'controlling mind' was required to be identified (Berry, 2006; Hofford, 2019; Waring, 2019). That is, a potential successful prosecution required that for an organization to be found culpable of manslaughter, a senior manager, the 'controlling mind' of the company, was also required to be found guilty of the charge (Daniels, 2013; Whyte, 2002). Since crimes generally require a criminal intention (*mens rea*) and a criminal act (*actus reus*), proving these elements for a corporation is problematic, since such an entity has neither a flesh-and-blood body nor a mind (Diamantis, 2016). Thus, it is easy to see why Clarkson (1996, p. 559) wrote, "the different structure of the health and safety offences contributes to the overall sense that death and injury at work is not a 'real crime'".

Historically, an accurate identification of the controlling mind was problematic, given a large organization's intricate and protective hierarchical structures (Gobert, 2005; Vucetic et al., 2023) and the distance between the managerial and operational levels (Almond & Colover, 2012). As Shapira stated (Shapira, 2022, p.229): "bigness reduces the chances of proving awareness."

Such an element may be more easily identified in the case of smaller companies. One example from the UK where a person's controlling mind was attributed to the company was in the case of *R v Peter Kite OLL Ltd*. Following the death of four teenagers in Lyme Bay in 1993, both the company, OLL Ltd which had organized the trip, and the managing director were convicted of manslaughter (Clarkson, 1996). The company was fined £60,000, and the managing director was jailed for three years which was later reduced to two years on appeal (Smaranda & Jacob, 2020).

The CMCHA, however, removed the *mens rea* defense, leaving an organization, and individual senior executives, open to prosecution if the way in which the organization was managed led to a workplace death (Waring, 2019). Well-known case studies are testament to the difficulty of successful prosecution owing to the inability of proving conclusively the controlling mind, or minds. In March 1987, the *Herald of Free Enterprise* capsized shortly after departing the Belgian port of Zeebrugge, causing the deaths of close to 200 people (Dalgleish et al., 2000; Dixon et al., 1993; Hofford, 2019). The formal investigation into the disaster, held between 27 April and 12 June, 1987, and chaired by Mr. Justice Sheen, was highly critical of the management of P&O European Ferries who owned the vessel.

In September 1990, eight defendants, including three former directors, stood trial for manslaughter (Woodman, 2007). After only a month, the judge directed the jury to acquit the defendants (Reason, 1997) as there was insufficient evidence that any of the defendants had the necessary *mens rea* (Michaelides-Mateou & Mateou, 2016; Rice, 2003). As an unknown commentator lamented: "The primary requirement of finding an individual who was liable … stood in the way of attaching any significance to the organizational sloppiness that had been found guilty by the official inquiry" (Cohen, 1995; as cited in Pettit, 2007, p. 171).

The tragedies in the UK did not end there. Over the next 30 months, there were no less than six large-scale disasters. As reported by Almond (2020), these included the fire at King's Cross station in November 1987 (31 dead), Piper Alpha in July 1988 (167 dead), Clapham Junction rail crash in December 1988 (35 dead), the Kegworth air crash in January 1989 (47 dead), the Hillsborough stadium disaster in April 1989 (96 dead), and the Marchioness on the River Thames in August 1989 (51 dead).

In each of these events, not one single member of the management structure for the organizations concerned was successfully prosecuted, leading to what Lawrenson and Braithwaite describe as "social intolerance" (Lawrenson & Braithwaite, 2018, p.258). In the case of Piper Alpha, which recorded the second highest death toll after the *Herald of Free Enterprise*, the international corporation which owned the platform escaped all criminal and civil sanctions (Hofford, 2019). Likewise, the Director of Public Prosecutions (DPP) chose not to proceed with any action in the case of the King's Cross station fire due to a lack of evidence, a decision which was strongly criticized (Ford, 1989).

5. Is the Corporate Manslaughter and Corporate Homicide Act 2008 (CMCHA) pulling its weight?

If the intention of the CMCHA was to ensure easier prosecutions of organizations, it has failed to live up to its expectation. The Regulatory Impact Statement, prepared at the time of the bill, estimated that enforcement of the Act would bring an additional 10–13 prosecutions each year (Home Office, 2006). While the CMCHA was not introduced to exchange the prosecution of companies for manslaughter for that of individual directors for gross negligence (Field & Jones, 2014), it was noted in the first decade of its existence that the Act was not achieving the prosecutorial expectations (Hebert et al., 2019).

It took over two years for the first prosecution under the CMCHA to result in a conviction (Roper, 2019). The company concerned, Cotswold Geotechnical Holdings Ltd, was prosecuted for the death of one of its employees, a geologist, following the collapse of a pit while the geologist was taking soil samples. Geotechnical had just eight employees (Parsons, 2018) and a sole director (Field & Jones, 2014). At conviction, the company was facing a potentially unlimited fine but was handed a fine of £385,000 (Roper, 2019). However, as argued by Field and Jones (2014), this was a substantial fine for the company, being equivalent to 250% of its annual turnover.

That successful conviction did little to whet the prosecutorial appetite. In the first decade of the Act, only 26 convictions were recorded (Roper, 2019), well below the number envisaged by the Regulatory Impact Statement. Of those convictions, almost all were small to medium enterprises, with just a single conviction of one large organization, that of *CAV Aerospace Ltd* (Roper, 2018). Criticisms of the apparent lack of action against large organizations have been cited as "impotent" (Field & Jones, 2014, p. 163) or that the Act itself is simply "symbolic" (Hebert et al., 2019, p. 3), particularly since one of the main objectives of the CMCHA was to create a more level playing field for all size of organization (Roper, 2018).

While the criticism from a purely statistical viewpoint may seem valid, the rate of prosecutions of smaller organizations should not come as any great surprise once viewed through a logical and unbiased lens. In his review of the first ten years of the CMCHA, Parsons (2018) argued that the fact that only small to medium organizations had been prosecuted was largely due to the prosecution's requirement to prove that death had occurred due to the way in which activities had been managed or organized by senior management, with such an obligation being far easier to establish in smaller organizations.

Some commentators have also suggested that the replacement of the identification doctrine with the new senior management test did little to improve the difficulty of convicting large companies (Spencer, 2022). It has been implied that the senior management test encapsulates all the nuances of the identification doctrine. As Haigh (2012) argues, the central aim of law reform is to improve upon that which was in place prior. With regards to whether the senior management test will improve the likelihood of successful prosecution of larger organizations, Haigh

states, "It is contended that the same problems will exist although we now have a new test to blame" (Haigh, 2012, p. 186).

Perez et al. (2017) and Roper (2018) offer an alternative view as to why only small to medium enterprises are apparently disproportionately before the courts. In the UK, over 99% of businesses are classified as small to medium and of which some 96% are categorized as micro (Roper, 2018). As reported by Perez et al. (2017), an organization is classified as small to medium if its annual turnover is below £36 million. Additionally, large companies account for only approximately 1% of all UK businesses but employ around 40% of all workers (Roper, 2018).

There is evidence in published literature that small to medium companies lack the necessary resources to stay informed of, and in compliance with, workplace health and safety obligations (Frick & Walters, 1998; Lingard & Holmes, 2001). In a highly competitive global marketplace, small companies are often forced to run lean to remain competitive and therefore a full-time safety resource is often out of the question. Large organizations are able to employ sufficient health and safety resources to remain aware of duties and obligations and implement appropriate policies, procedures, supervision and training.

One of the most common criticisms of the CMCHA has been the inconsistencies with which the sentencing guidelines have been applied (Roper, 2018). As Field and Jones (2014, p. 163) report, the courts were accused of "lightning the seriousness of corporate killing". Hebert et al. (2019) suggest that the sentencing guidelines proposed that fines imposed by the courts should be such so as to reflect the public's concern around workplace deaths and to deter organizations from breaching duties under the CMCHA which led to a worker's death. However, the penalties imposed during those first ten years in the UK did little to meet either one of those two requirements. Fines meted out in the first decade of the CMCHA coming into force ranged from a mere £12,000 to £700, 000 (the latter coming after the revision of the sentencing guidelines in 2015). Prior to the revision, the largest fine imposed was £500,000 (Perez et al., 2017). Such inconsistencies in the levels of penalties are already being reported in Australia since the introduction of the harmonized legislation (Johnstone, 2020).

While legislation has been adapted over time to improve working conditions, the fact of the matter is that since the introduction of the CMCHA in the UK, workplace fatalities have generally not seen a significant downward trend (refer to trend line in Fig. 1). Indeed, some commentators argue that larger organizations are escaping liability at the expense of small to medium enterprises, which tend to pay more for health and safety offences at a ratio of 1:2 (Arewa et al., 2018).

The information in Fig. 1 was adapted from information in the annual reports of the Health and Safety Executive, UK from 2009 to 2023. The fatal injuries reported in Fig. 1 do not include work-related fatalities such as traffic incidents, and deaths from occupational diseases (HSE, 2024). In both the UK and Australia, prosecutions to date have been for accidental death through a person being fatally injured. There have been no industrial manslaughter charges for employee deaths due to an occupational disease. According to International Labor Organization statistics more people die due to work related occupational diseases than due to occupational accidents (ILO, 2023).

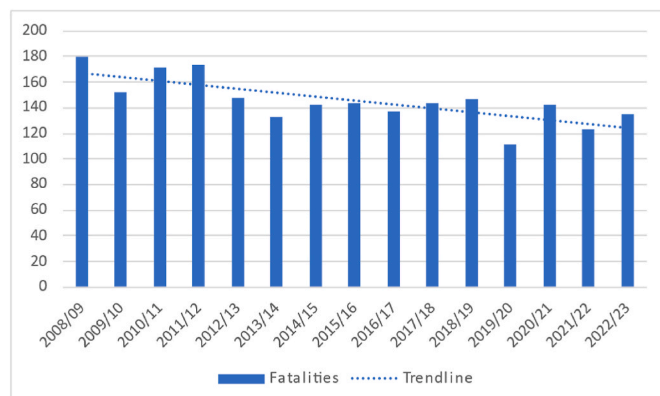

Fig. 1. Workplace fatalities in the United Kingdom – 2008/09 to 2022/23.

6. One philosophy: separated by a common language

There can be little doubt that the primary philosophy of both the United Kingdom and Australian legislative method is ultimately to keep workers safe and healthy at work. The prevention of harm at work is an expectation of the International Labor Organization which states: "a safe and healthy working environment is a fundamental principle and right at work" (ILO, 2022, p. 1).

Both the Model WHS Act and the CMCHA provide thorough descriptions of duties owed under duty of care provisions. Many of the duties outlined in the Model Act are not included in the CMCHA but are included in the UK's Health and Safety at Work Act 1974. The offence provisions of the CMCHA stipulate that an offence is committed if a person's death is caused by the way in which an organization's activities are managed (s.1(1)). Similarly, the Model WHS Act, under its gross negligence provisions specifies that the body corporate may commit gross negligence through "inadequate corporate management, control or supervision of 1 or more authorised persons" (s.244BA.2(a)). Table 2 below provides a comparison of the offence provisions of the two Acts.

One distinct difference between the two legislations is that of individual liability. While the Model WHS Act (and the states and territories that have adopted its premise) hold individuals, including employees, culpable of an offence committed, the CMCHA has no provision for individual liability and therefore no ability to prosecute senior managers and executives. This has left some authors to lament on the fact that it appears that it remains easier to prosecute smaller companies under the CMCHA, while senior managers in larger organizations remain behind a 'corporate veil' (Tombs, 2018) or 'shield' (Spencer, 2022). Prosecutorial action to be taken against individuals remains under the jurisdiction of the UK's *Health and Safety at Work etc. Act 1974*.

A significant introduction to the Model WHS Act which already existed within the CMCHA is that of corporate culture. Under the model Act, the culture of an organization may be taken into consideration when determining offences other than gross negligence where 'a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the carrying out of the conduct constituting the physical element of the offence" (s.244B.1(c)). In comparison, the CMCHA provides guidance for a jury to consider "attitudes, policies, systems or accepted practice" (s.8.3(a)). Health and safety literature is heavy with the notion and criticality of workplace culture, so the application of these two separate sections should be closely monitored and lessons drawn from the outcomes.

7. Prosecution: an effective deterrent?

So far, this paper has commented on the fragility of prosecutions to hold the responsible people to account. There have, however, been criticisms in the past of workplace safety prosecutions in that the very process of the prosecution "decontextualizes and trivializes" the failure of organizations to comply with safety standards" (Hall & Johnstone, 2005, p. 86). Indeed, it has been argued that the fact that many of these prosecutions are held in the lowest court – the Magistrates' court – further advances the notion that breaches of workplace health and safety law are considered in the same vein as minor or petty crimes and with little public scrutiny (Johnstone, 2003). The question that needs to be considered, therefore, is whether prosecution has been, or will be, an effective deterrent.

The concept of deterrence is relatively straightforward: it is simply "the omission of a criminal act because of the fear of sanctions or punishment" (Paternoster, 2019, p.766). The effectiveness of prosecution as a deterrent, however, for both the offender and potential offender is the

Table 2
Offence provisions of the model WHS Act and the CMCHA.

Model WHS Act	CMCHA
s.30A Industrial manslaughter Jurisdictional note: Each jurisdiction may insert local provisions to create an offence of industrial manslaughter. The offence of industrial manslaughter would be in addition to the existing offence under section 31 and address conduct by a person that represents a gross deviation from the reasonable standard of care resulting in a work-related fatality. **s.31 Gross negligence or reckless conduct – Category 1** (1) A person commits a Category 1 offence if: (a) the person has a health and safety duty; and (b) the person, without reasonable excuse, engages in conduct that: (i) exposes an individual, to whom the duty is owed, to a risk of death or serious injury or illness; or (ii) if the person is an officer of a person conducting a business or undertaking—exposes an individual, to whom the person conducting a business or undertaking owes a health and safety duty, to a risk of death or serious injury or illness; and (c) the person: (i) engages in the conduct with gross negligence; or (ii) is reckless as to the risk to an individual of death or serious injury or illness. **Offences by bodies corporate: s.244BA Gross negligence** (1) If gross negligence is a fault element in relation to the commission of the physical element of an offence, the fault element may exist on the part of a body corporate, despite no individual authorised person of the body corporate having the fault element, if the body corporate has engaged in conduct with gross negligence when viewed as a whole, determined by aggregating the conduct of more than 1 authorised person. (2) For the purposes of subsection (1), gross negligence may be evidenced by the fact that the prohibited conduct was substantially attributable to: (a) inadequate corporate management, control or supervision of the conduct of 1 or more authorised persons; or (b) failure to provide adequate systems for conveying relevant information to relevant persons in the body corporate.	**The offence s.1.1** (1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised— (a) causes a person's death, and (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased. (2) The organizations to which this section applies are— (a) a corporation; (b) a department or other body listed in Schedule 1; (c) a police force; (d) a partnership, or a trade union or employers' association, that is an employer. (3) An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1).

subject of debate. In a small study conducted in Australia of prosecuted companies, McLean (1998) failed to find a positive impact following prosecution and that company executives were still focusing on productivity and profits as a major consideration for implementing health and safety preventative measures. However, as Gunningham (2007) reports, deterrence may well be more successful in small to medium enterprises rather than larger ones given the simpler management structure and the ease of prosecutors to identify the key decision makers.

In the United Kingdom, prosecutions under the CMCHA have fallen well short of what was expected, not only in the number of successful prosecutions but also in the level of fiscal punishments being handed to the guilty, both of which have failed to reach the estimates of the CMCHA. It is not unreasonable that society, those served by this new legislative instrument, should demand fair and equitable treatment of offenders "whether they be 'conventional' or corporate" (Perrone, 1995, p. 83).

Bluff and Johnstone (2017) suggest that Work Health and Safety (WHS) regulators principally prosecute as a 'political' response to deter offenders from repeat offences and also to act as a general deterrent. The courts have made it clear that the primary purpose of prosecution is that of deterrence (Johnstone, 2013). However, research conducted by McCallum et al. (2012) suggests that even the judges themselves are somewhat skeptical about the deterrent impact of their decisions despite knowing that one of the main features of their role is to deter subsequent offences, and offenders. Some authors have argued that the general philosophy behind deterrence theory is that the threat of being caught is the actual greater deterrent rather than the prosecutorial action and the subsequent consequences of being caught (Sarre, 2010; Schofield et al., 2014).

As reported by Matthews et al. (2022), light penalties may not reflect the seriousness of a breach of the health and safety duties by an employer, nor act as a sufficient deterrent to further non-compliance by the offending entity. While there has been some anecdotal evidence in Australia that increased fines were having an appropriate effect on deterring offenders (Johnstone, 2003), it is noted by Faure and Tilindyte (2010) that the use of fines as a punishment to organizations is not unproblematic. They argue that such fines "only work in case of full solvency of the employer who has sufficient assets to pay them. In cases of insolvency, applying fines may lead to under-deterrence" (Faure & Tilindyte, 2010, p.349). It has also been reported that fiscal penalties may not be effective for other reasons. In a study conducted by Thornton et al. (2005), involving environmental prosecutions in the United States, it was found that fines were not having the desired deterrent effect as organizations were not actively monitoring fines imposed against other companies for both frequency of prosecution and the magnitude of the penalty. Their research concluded that it is the fear of sanctions and the potential reputational damage which drives environmental compliance.

It may be that punitive measures alone will not be sufficient to deter corporate misconduct. One approach which is highly regarded is that of the 'enforcement pyramid', developed by Ayres and Braithwaite (1992). At the pyramid's foundation, regulatory authorities may deploy persuasive and cooperative approaches to guide and encourage an organization to fulfil its fundamental health and safety obligations or minor sanctions such as improvement and prohibition notices. Prosecutions, the pyramid's apex, are reserved for the most egregious corporate wrongdoing, where disregard for legislative requirements has led to a serious event. In the enforcement pyramid, a low number of prosecutions does not necessarily signal failure of the enforcement process and should be taken seriously when they do occur (Davies & Rodgers, 2023).

8. Conclusions and recommendations

The aim of this paper was to explore the industrial manslaughter legislation across Australia and discuss the lessons which may be learned from the UK. The bold prediction of the CMCHA to enable prosecutors to bring large organizations before the courts have not yet materialized. Reviews of the UK's CMCHA have drawn attention to the prosecutorial failings in both the number of cases brought before the courts and the inconsistent level of financial penalty applied to organizations that have failed in the duty of care obligations to workers, and their families. Most importantly, however, is the fact that the Act has had negligible impact on reducing the number of workplace fatalities as the number per year remain largely unchanged since the CMCHA entered law (at least for those which have been recorded by the UK's Health and Safety Executive).

Conclusions are that there are a great many lessons to be learned for Australian jurisdictions from the UK's CMCHA. In the UK, managers and executives in large organizations have, in the past, slipped through the prosecutorial process, disguised and protected behind an organizational structure which prevented prosecutors from bringing charges. The lessons of the past do not appear to have been sufficiently learned as once again commentators in the UK have documented the one-sidedness of the CMCHA (Field & Jones, 2014; Hebert et al., 2019), and at the ease at which small organizations are being prosecuted while larger organizations avoid prosecution.

Sections 2 and 3 of this paper outlined the process across Australia of implementing the industrial manslaughter legislation and provided a summary of prosecutions to date. Conclusions are that if the Australian Federal, State and Territory governments' ambition is to have effectual workplace health and safety legislation in place, then the criticisms of the UK's CMCHA need to be considered. The work health and safety legislative instruments that are now in effect across Australia must try to better balance the principles of accountability and fairness by ensuring all sizes of organizations are prosecuted appropriately.

Section 4 analyzed the implementation of the CMCHA in the UK following criticisms of the lack of action against large organizations in the aftermath of major disasters pre-CMCHA. The paper outlined the difficulties of previous legislation in identifying the controlling mind of complex organizations to bring about successful prosecution and how in the past, the public – those supposedly protected by workplace safety legislation – have felt aggrieved at the apparent lack of accountability for large organizations in the courts while small companies have seemingly borne the brunt of successful prosecution. A conclusion drawn from this analysis is that organizations are not always learning from prosecution and rehabilitating into good corporate citizens. As prosecution case numbers grow over the coming years, an analysis should be undertaken to compare the Australian experience of prosecution outcomes to that of the UK.

In Section 5, the performance of the CMCHA was critically assessed. From this review, the CMCHA fell well short of the expectations it was designed to deliver in its first decade of existence. The number of successful prosecutions for all sizes of company were significantly below estimates, with some commentators bemoaning the ongoing sins of large corporations. The paper also discussed a logical analysis of why smaller companies continue to be over-represented in the UK's prosecution statistics and concludes simply that smaller organizations, given the sheer weight of numbers (approximately 99% of all companies in the UK), are more likely to find themselves before the courts. A summary of the offence provisions of both Acts was provided in Section 6.

While this paper provided a critical analysis of prosecutions under industrial manslaughter in the UK, it also questions the concept of prosecutions as a means of effective deterrent for future serious WHS breaches. Section 7 discussed whether the process of prosecutions, as it currently is, is having the desired effect of preventing repeat and first-time offenders. Certainly, researchers have found that the prosecution of organizations may not necessarily deter others, as active monitoring of court outcomes is not wildly undertaken. Indeed, there is evidence presented in this paper that the courts themselves are skeptical and corporate ambivalence continues from organizations who have been prosecuted as productivity and profits continue to be a very much more favorable focus. While the previously inadequate monetary penalties have increased across all Australian jurisdictions for significant WHS breaches, lessons can be learned from the failure of the UK courts to generally apply fines in line with the CMCHA sentencing guidelines. It is recommended that this is a fact that Australia takes note of. There is an opportunity for future research on whether prosecution under the new WHS legislation in Australia of first-time offenders truly guides the organization to make genuine attempts at redemption and why a recidivistic organization continues to gamble with its profits and, more importantly, its workers' health and safety.

As Woolf (1973) once lamented, an employer who is indifferent to its WHS obligations sees the regulator as little more than a paper tiger with rubber teeth. It is hoped in the future that organizations take note of work health and safety legislation and implement robust health and safety systems to create safe work practices and safe workplaces.

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